

Section III

Federal Award Findings and Questioned Costs

Department of Health Care Policy and Financing

Introduction

The Department of Health Care Policy and Financing develops financing plans for public health care programs. It spent \$1.91 billion to administer its programs including Medicaid and the Children's Basic Health Plan. The following comments were prepared by the public accounting firm of Baird, Kurtz & Dobson, who performed audit work at the Department of Health Care Policy and Financing. Please refer to page 43 in the Financial Statement Findings section for additional background information.

Obtain Approval for Cost Allocation Plan

Indirect costs, or overhead costs, benefit more than one program. A portion of indirect costs may be recovered by federal dollars based upon an approved cost allocation plan. The Department had not submitted a plan for Fiscal Years 2000 and 2001. Please refer to Recommendation No. 5 in the Financial Statement Findings section for additional details, our recommendation, and the Department's response.

Ensure Costs Are Allowable

Under the federal Medicaid program, certain expenditures are considered allowable costs and thereby qualify for reimbursement by the federal government. Total Medicaid program expenditures, excluding administrative costs, were over \$1.89 billion for Fiscal Year 2000, which represents a federal share of just under \$1 billion. The audit tested a sample of 208 program expenditures and credits with a net value of \$89,987 (federal share \$45,128) for allowability under Medicaid regulations.

The types of errors identified in the sample are similar to those found during the Fiscal Year 1999 audit. The most prevalent problem was that providers' files for the Medicaid program generally lacked Electronic Data Interchange (EDI) agreements. EDI agreements are the providers' attestation that they have appropriate medical records to support electronic claims submitted in batches for payment under Medicaid. The two other areas where errors were again identified—collections from third-party resources and follow-up

on prescription credits—showed some improvement from Fiscal Year 1999. Overall, evaluation of the sample identified 202 program expenditures that did not comply with one or more of these allowable cost criteria for the Medicaid program. These 202 items had a value of \$93,454 (federal share \$46,867). The errors were as follows:

Third-Party Resources: There was one instance in which there was no evidence noted in the file showing efforts to bill a third-party resource, although the beneficiary's third-party resource information was entered into the Medicaid Management Information System (MMIS). Third-party resources should be exhausted prior to paying claims with Medicaid funds. In addition, federal regulations state that where a third-party liability is established after the claim is paid, reimbursement from the third party should be sought (42 CFR sections 433.135 through 433.154). The Department risks being required to refund federal reimbursement dollars if third-party resources are not properly pursued and billed.

Electronic Data Interchange Agreements and Adequate Support for Claims : There were 202 instances in which an Electronic Data Interchange agreement was not provided for review. By not confirming these agreements are in place with providers, the Department does not adequately ensure providers are aware of their obligation to have medical records to support the claims submitted. Payments for claims unsupported by medical records are not allowed under the Medicaid program.

Prescription Credits: There were 20 sample items in which documentation was not present to indicate whether prescriptions were actually picked up by the Medicaid recipient within the prescribed 14-day period. Regulations allow the costs for prescriptions to be billed only if the recipient obtains the prescription within 14 days. Should a recipient not pick up a prescription within that time frame, the provider is required to credit the original cost back to the program. This requirement is stated clearly in the Pharmacy Provider Manual supplied by HCPF.

Effective June 1, 2000, HCPF approved an amendment to the pharmacy provider agreements, requiring the provider to maintain a signature log documenting the signature of the Medicaid recipient and the date the prescription was picked up. These signature logs will greatly assist the Department with post-payment reviews. The Department has not yet developed a process to review these signature logs to ensure the Medicaid program receives credit for prescriptions not claimed within 14 days. (CFDA Nos. 93.777, 93.778—Medicaid Cluster—Allowable Costs.)

Recommendation No. 34:

The Department of Health Care Policy and Financing should ensure payments are made only for allowable costs under the Medicaid program by:

- a. Implementing control procedures to ensure Medicare or other third-party resources are exhausted.
- b. Ensuring that Electronic Data Interchange agreements are current for every provider submitting batch transactions before payment is made for those claims.
- c. Monitoring pharmacy providers' compliance with newly adopted requirements to maintain chronological logs with Medicaid recipient signatures and following up as appropriate to ensure credits are received for prescriptions not claimed within 14 days.

Department of Health Care Policy and Financing Response:

- a. Agree. For the claim in question, the system error that allowed that claim to be processed without the proper edit set was identified and fixed April 2000. For Provider Type 1 - hospitals - the system parameter was set to ignore the third-party resource edit. All claims for that time period (October 1999 to March 2000) were pulled during April 2000. Providers were sent the intent to retract notices in order to comply with all regulations. That correction did not identify those claims to be billed to the carrier as pay and chase claims versus cost avoid claims. With the identification of that problem for this claim, a review will be done of claims processed when the edit was turned off for Type 1 Providers, and appropriate carrier billings completed. The review of these claims should be finished by the end of March 2001.
- b. Agree. The Department is working with the fiscal agent to re-enroll all providers (please see response to Recommendation No. 34a for time frames). The EDI agreement is part of the provider application. As providers enroll, the EDI agreements are mandatory and as the provider re-enrollment efforts continue, all EDI agreements will be updated.

- c. Agree. Beginning with Fiscal Year 2001, the Department in association with the Medicaid Fraud Unit will perform random audits to assure compliance with the department's rules regarding the maintaining of chronological logs and the ensuring of appropriate credits for those prescriptions not claimed in 14 days.

Perform Reviews of Controls Over Automated Systems

The Medicaid program is dependent on extensive, complex computer systems and the internal controls over such systems for ensuring the proper payment of Medicaid benefits. Federal regulations (45 CFR 95.621) require state agencies to establish and maintain a program for conducting a biennial risk analysis and security review of automated systems for the Medicaid program. The purpose of these requirements is to ensure that appropriate, cost-effective controls and safeguards are incorporated and operating as intended in Medicaid claims payment systems. HCPF contracts with a nongovernmental service organization that functions as the fiscal agent for the Medicaid program and is responsible for the operation of the Medicaid Management Information System (MMIS).

During the Fiscal Year 1999 audit we found that the Department had not performed and documented the required on-site risk analysis and system security review for MMIS. The Fiscal Year 2000 audit found that this deficiency has not yet been addressed. This is a concern because MMIS processes all claims for payment under the State's Medicaid program; in Fiscal Year 2000 alone this represents over \$1.89 billion in claims payments. HCPF also has not obtained an independent audit of the controls over MMIS or other documentation demonstrating that controls over the system have been verified.

The Fiscal Year 2000 audit did note that in October 1999 the Department received certification from the Health Care Financing Administration. This certification approved a 75 percent federal financial participation rate for the operation of the new MMIS retroactive to December 1, 1998, the implementation date of the current system. However, this certification does not alleviate the Department of its responsibility to perform the required on-site risk analysis and system security review for MMIS.

It is important that the Department meet the requirements related to MMIS to help ensure adequate controls are in place and payments are appropriate. (CFDA Nos. 93.777, 93.778—Medicaid Cluster—Special Tests and Provisions (Automated Data Processing)).

Recommendation No. 35:

The Department of Health Care Policy and Financing should ensure adequate controls are in place over automated systems for the Medicaid program by:

- a. Performing and documenting the required analysis under federal regulations for the MMIS and following up on any corrective action deemed necessary as a result of that analysis.
- b. Consider including a requirement that the fiscal agent obtain an independent assessment of controls over the Medicaid Management Information System.

Department of Health Care Policy and Financing Response:

- a. Agree. The Department has followed up on the recommendation from last year and performed a Systems Security Review to ensure that security procedures, contingency plans and emergency preparedness plans are updated and in place. Areas identified are in the process of being addressed. The Department will perform the required risk analysis and formalize the report on both the security review and the risk analysis in Fiscal Year 2001. Although documentation was not provided to the auditor for Fiscal Year 2000, this will be available and provided for the Fiscal Year 2001 audit.
- b. Agree. Having an independent assessment is a valuable suggestion. The fiscal agent has prepared estimates to perform such an assessment. This will become a contract item with re-negotiation to occur this next contract year. Depending on funding this item may or may not be included. This will be resolved during Fiscal Year 2001.

Improve Oversight Over Eligibility

The audit reviewed the Department's procedures for complying with federal requirements for determining the eligibility of the individuals who receive benefits and the providers who receive reimbursements under the Medicaid program. HCPF has established an agreement with the Department of Human Services to oversee the determination of

individuals' eligibility for Medicaid through entities that serve as Single Entry Points (SEPs) for the Medicaid program. These are typically county departments of social services. For providers, HCPF contracts with its fiscal agent, a nongovernmental service provider, to determine providers' eligibility for receiving Medicaid payments. Nonetheless, under federal regulations the Department of Health Care Policy and Financing remains ultimately responsible for the Medicaid program. This means that HCPF must have controls in place to ensure compliance with state and federal regulations for all aspects of the Medicaid program, whether performed directly by the Department, or by another entity through contractual or other formal agreements. As mentioned above, in Fiscal Year 2000 HCPF paid Medicaid benefits to various providers in excess of \$1.89 billion on behalf of individual beneficiaries.

In the Fiscal Year 1999 audit HCPF received an audit comment because errors were found in both individual and provider eligibility; these errors generally related to lack of documentation. The Fiscal Year 2000 audit found that controls had been strengthened over the SEPs and that there were fewer errors in the area of individual eligibility determination. However, in the area of provider eligibility, we again found a significant number of instances in which the documentation of required licenses was lacking.

Individual Eligibility

The audit tested 208 expenditures, and we identified 2 instances of individual eligibility errors with a value of \$1,229 (federal share \$616) described as follows:

- In one instance, a beneficiary's file did not contain information sufficient to determine whether the individual was eligible to receive services under the Medicaid program.
- In another instance, a beneficiary's case file indicated the individual was not eligible, although benefits were paid on behalf of the individual.

According to federal regulations, individuals must be eligible for the Medicaid program in order to receive benefits (42 CFR Part 435, Subparts G and H). By not ensuring that SEPs are adequately and appropriately determining client eligibility, HCPF risks that benefits may be paid on behalf of ineligible individuals. If such payments are made as a result of errors in the eligibility determination process, HCPF would have to repay to the federal government any Medicaid monies previously reimbursed to the State for these individuals.

While HCPF's eligibility payment error rate is below the federal standard of 3 percent for the Medicaid program, the Department should continue to improve controls to ensure that benefits are paid only for eligible individuals and that information maintained in client files adequately documents individuals' eligibility. (CFDA Nos. 93.777, 93.778—Medicaid Cluster—Eligibility (Client Eligibility).)

Recommendation No. 36:

The Department of Health Care Policy and Financing should strengthen controls over the eligibility process for individuals under the Medicaid program by:

- a. Working with the Department of Human Services to implement control policies and testing procedures to ensure all Single Entry Points are maintaining current and complete files for Medicaid-eligible beneficiaries.
- b. Establishing control procedures to ensure claims are not paid for an individual who is ineligible for benefits and to ensure individuals no longer meeting eligibility requirements are disenrolled from the Medicaid program.

Department of Health Care Policy and Financing Response:

- a. Agree. The case record at the SEP must contain all the documentation elements to verify proper determination of Medicaid eligibility. When a determination is made that the client is no longer functionally eligible, this must be communicated to the county department of social service and documented in the case record. HCPF will continue to work with the Colorado Department of Human Services to strengthen and monitor the controls on Medicaid eligibility to ensure the case records contain accurate documentation supporting Medicaid eligibility for covered services on an ongoing basis.
- b. Agree. The Department agrees that only individuals eligible for Medicaid should receive benefits. In an effort to increase the accuracy of eligibility determinations, the Eligibility section has increased its training efforts over the last three years to provide semi-annual training on Medicaid eligibility across the State. We have also updated eligibility rules and clarified their application through numerous agency letters to counties.

The Department will continue to train counties in proper determination procedures and will continue our internal quality assurance reviews to assure a very high level of accuracy in the application of eligibility rules in Fiscal Year 2001.

Provider Eligibility

HCPF's fiscal agent is responsible for determining the eligibility of providers to receive reimbursement for services under the Medicaid program. As part of this, the fiscal agent is required to maintain documentation to support that the medical providers are licensed in accordance with federal, state, and local laws and regulations (42 CFR sections 431.107 and 447.10; Section 1902(a)(9) of the Social Security Act).

Out of the sample of 208 Medicaid expenditures tested, the audit found 118 instances of provider eligibility errors related to lack of documentation of required licenses and registrations. In some cases more than one type of error was identified with a particular provider. The total value of payments made to providers in the sample for which one or more errors were identified was \$42,978 (federal share \$21,553). The audit identified the following errors:

- 57 provider files did not contain a signed copy of the provider agreement. According to federal regulations (42 CFR §431.107), there must be an agreement between the state Medicaid agency and each provider furnishing services for which reimbursement is claimed.
- 94 provider files lacked documentation of one or more required licenses as follows:
 - T 63 providers lacked the required license from the Department of Public Health and Environment.
 - T 3 transportation services providers lacked the required state license.
 - T 9 physician services providers lacked the required state license.
 - T 7 dental services providers lacked the required state license.
 - T 2 pharmacy providers lacked the required pharmacy license.
 - T 31 laboratory services lacked the required registrations/waivers.

If payments are made to ineligible providers, the Department would have to refund monies previously reimbursed to the State by the federal government. Therefore, the Department should ensure that the fiscal agent meets requirements related to provider eligibility. (CFDA Nos. 93.777, 93.778—Medicaid Cluster—Eligibility (Provider Eligibility).)

Recommendation No. 37:

The Department of Health Care Policy and Financing should improve controls over provider eligibility by:

- a. Requiring the fiscal agent to review all provider files to ensure each file includes a current provider agreement and documentation of applicable provider licenses and registrations.
- b. Revising control procedures to ensure expenditures are made only to eligible providers.

**Department of Health Care Policy and Financing
Response:**

- a. Agree. The Department has several efforts under way according to its 5-year plan to perform a review of all providers by July 1, 2005. The plan has divided the providers into 4 groups:
 - Group1 - Providers with Post Office Box addresses only.
 - Group2 - Providers with unknown or incorrect mailing addresses.
 - Group3 - Providers without a known regulatory oversight agency.
 - Group4 - Providers without a PUC license or certificate who transport wheelchair and other special needs clients.

Group1 has been completed and research has begun relating to group 2.

The Health Insurance Portability Accountability Act (HIPAA) is defining standards for data to be collected as a part of provider taxonomy. When final rules are published, this process will drive additional efforts to collect and categorize the data. The Department will coordinate and schedule these two efforts so as not to perform the requests for data twice.

- b. Agree. The Department agrees that effective controls need to be in place to ensure only eligible providers are paid. As noted in part "a," the Department will develop re-enrollment procedures on a systematic basis to continually monitor the eligibility of the providers who receive Medicaid funds. The Department will investigate costs associated with developing system interfaces with the Department of Regulatory Agencies by June 1, 2001.
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Managed Care Programs and Complaint Systems

HCPF has a waiver from the federal government allowing the Department to operate a Managed Care Program (MCP). Under the Managed Care Program, the Department is required to ensure that beneficiaries have adequate access to health care through the MCP. Medicaid pays premiums on behalf of the beneficiaries served to the managed care organizations participating in the MCP.

As part of the audit a sample of 30 managed care organization billing submissions and related agreements and other documentation was selected for testing out of a population of 788 such organizations under the Department's MCP. We found one organization that did not maintain adequate complaint logs showing participant identification numbers and reason codes for the types of complaints received.

Another aspect of the Department's managed care program is the Program of All-Inclusive Care for the Elderly (PACE). The Department did not provide any complaint logs for PACE to us, and as a result, we were unable to verify that such logs were maintained or the adequacy of the logs. Providers under PACE are required to maintain adequate complaint logs under the 2000 PACE Managed Care contracts.

In the Fiscal Year 1999 audit, the Department also received a recommendation regarding the need to improve complaint logs in the managed care program. The Department should take steps to address these issues to ensure the providers and HCPF receive feedback about the services furnished. (CFDA Nos. 93.777, 93.778—Medicaid Cluster—Special Tests and Provisions (Managed Care Program).)

Recommendation No. 38:

The Department of Health Care Policy and Financing should ensure all necessary information is maintained regarding complaints under the Medicaid Managed Care Program by:

- a. Continuing to monitor providers in the managed care program and following up on those not meeting requirements for complaint logs.
- b. Verifying that providers under the Program of All-Inclusive Care for the Elderly (PACE) adhere to requirements related to patient complaint logs.

Department of Health Care Policy and Financing Response:

- a. Agree. The Department concurs that monitoring of complaint logs is an important part of monitoring the managed care program. The Department continues to monitor the HMO complaint logs and corrective actions taken by the HMO.
- b. Agree. The PACE Health Plan Manager receives copies of all complaints, including resolutions, from PACE quarterly. The complaints are reviewed by the PACE Health Plan Manager. If upon review the Pace Health Plan Manager identifies additional concerns or issues, or is not satisfied with the resolution of a complaint, appropriate departmental personnel further investigate the issue.

Each Contractor under PACE is required to establish and maintain a timely and organized system(s) for recording, tracking, and resolving participants' complaints and appeals, which shall include the category of the complaint, date received, resolution, name and identification number of the participant, and identity of the providers involved. Though the complaint logs were not made available to the auditor at the time of the audit, the logs will be provided for the auditor's review in the Fiscal Year 2001 audit.

Maintain Adequate Documentation in Case Files

In both the Fiscal Year 1999 and Fiscal Year 2000 audits, we noted during testing that the case files from the Colorado Medicaid Fraud Unit (MFCU) were disorganized and that the chronological logs used to document the progress of the cases were incomplete. In order to learn the disposition of the cases tested, the auditors were required to interview the respective investigator for the case. This lack of documentation results in dependence on Department personnel, which could become a problem if staff turnover occurs or if personnel must be absent for other reasons. HCPF should ensure that adequate documentation exists in the files to enable personnel other than the investigator to reasonably determine the progress and disposition of fraud cases that are under investigation.

In addition, in Fiscal Year 2000 during testing of 30 Program Integrity Unit case files we noted one file was missing a required signature and another file was missing required

documentation based on the Quality Assurance Policy and Procedures. HCPF should ensure all documentation is included in case files in accordance with the established Quality Assurance Policy and Procedures to ensure program integrity. (CFDA Nos. 93.777, 93.778—Medicaid Cluster—Special Tests and Provisions (Fraud & Program Integrity).)

Recommendation No. 39:

The Department of Health Care Policy and Financing should improve documentation of fraud and program integrity cases by requiring that case files contain all required supporting documentation and approvals. In addition, documents in fraud cases should be maintained in chronological order from case opening to disposition with a corresponding log of the case history.

Department of Health Care Policy and Financing Response:

Agree. The Medicaid Fraud Control Unit (MFCU) is housed with the Department of Law, not the Department of Health Care Policy and Financing. However, the Department of Health Care Policy and Financing will bring up the concern from the Office of the State Auditor with the MFCU during our next meeting time. We will also propose to MFCU that a requirement for files to be organized and well-documented be added to our Memorandum of Understanding for the period beginning July 1, 2001.

We agree that HCPF file documentation for program integrity cases should also be complete, and it is required in the Quality Assurance Policy. We agree to attempt to improve our internal processes in order to increase our 97 percent compliance to 100 percent during State Fiscal Year 2001.

Auditor Addendum: The Department of Health Care Policy and Financing's response notes that the Medicaid Fraud Control Unit is located at the Department of Law, not within HCPF. However, as mentioned earlier, under federal regulations HCPF is responsible for the administration of the State's Medicaid program. Therefore, HCPF is responsible for ensuring case file information is appropriately maintained by the Medicaid Fraud Control Unit.

Review Regulatory Requirements for Cost Audits of Long-Term Care Facilities

The Department of Health Care Policy and Financing is responsible for establishing the rates for inpatient care used to reimburse long-term care facilities in the Medicaid program. During Fiscal Year 2000, there were 198 long-term care facilities in the State that participated in the Medicaid program. These facilities received approximately \$360 million in payments in Fiscal Year 2000 out of total Medicaid benefit payments of \$1.89 billion. Under state regulations, HCPF is required to reimburse the facilities for the reasonable costs of operating an efficiently-run facility within the parameters and maximum rates described in the regulations.

Each year facilities are required to submit cost reports and related information to HCPF. The Department is responsible for reviewing this information and determining the allowable average daily cost, or per diem rate, for each facility under Medicaid regulations. Per diem rates are established for each facility annually. Under state statutes the Medical Services Board is responsible for establishing all state regulations for the Medicaid program, including those that govern rate-setting for the long-term care facilities.

The Department contracts with an accounting firm to complete the audits of long-term care facility costs. The firm reviews information from each facility and recommends to HCPF the rate that should be used for reimbursement for the applicable period. The Department is responsible for reviewing the firm's recommendations, issuing approvals of rate changes as appropriate, and implementing the rate changes.

State regulations allow the Department to conduct cost audits in one of three ways: by performing a rate calculation, desk review, or an on-site field audit at the facility.

The audit comment that follows was prepared by our staff during the Fiscal Year 2000 financial and compliance audit of the Department of Health Care Policy and Financing.

Regulatory Requirements and Types of Cost Audits

We found that the Department is not conducting cost audits of long-term care facilities on a basis that is consistent with state regulatory requirements in two respects. First, regulations require that a field audit should be conducted on each facility every third year. Out of our sample of 23 facilities, we found that 6 facilities should have received a field audit, according to the requirement in the regulations. Instead, on the basis of a risk

assessment performed by the contractor, the Department had approved these long-term care facilities to receive either a rate calculation or a desk review.

Second, if the facility's reported costs exceed the maximum per diem rate established under regulations by \$5 or more, regulations require that a rate calculation be used to satisfy the audit requirement. Staff state that regulations provide for the use of a rate calculation in these situations because reimbursement rates are capped at the maximum allowable rate, and thus any reported costs above that rate cannot be reimbursed. However, we found that HCPF requires the contractor to perform a rate calculation in cases where the reported costs exceed the maximum per diem by only \$2 or more. In other words, the Department requires a rate calculation to be performed at a lower threshold than that provided in state regulations.

The Department should evaluate current practices for determining the type of cost audits to be performed at facilities and then take appropriate action to ensure regulatory requirements and actual practices are aligned. (CFDA Nos. 93.777, 93.778–Medicaid Cluster–Special Tests and Provisions (Inpatient Hospital and Long-Term Care Facility Audits).)

Recommendation No. 40:

The Department of Health Care Policy and Financing should review regulations for determining the type of cost audits to be performed at long-term care facilities and current practices by:

- a. Evaluating the risk assessment methodology employed by the contractor as the basis for recommending the type of cost audits to be performed at long-term care facilities.
- b. Assessing the appropriateness of using the \$2 instead of the \$5 threshold as the basis for performing a rate recalculation for a facility.
- c. Proposing changes in existing regulations as needed.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees with the above recommendations. (This response concerns the rate-setting rules and practices for Colorado nursing facilities, as

distinguished from other types of long-term care facilities such as alternative care facilities (ACFs) and adult foster care (AFC) homes.) In fact, this winter the Department intends to ask the Medical Services Board to approve changes to pertinent regulatory language, effective May 1, 2001. Those changes, if approved, will (1) give the Department the discretion to choose among the three methods of Medicaid cost audits, "based on the consideration of appropriate risk-analysis factors," (2) eliminate the \$5 dollar threshold (or any other dollar amount) as a basis for performing a rate calculation, and (3) eliminate the requirement that a nursing facility receive an on-site field audit at least once every three years. In addition, the Department intends to work closely with its contract auditor in establishing and applying suitable risk-analysis criteria for determining the most appropriate audit method for a particular nursing facility. The risk-analysis criteria will be finalized by July 1, 2001.

Oversight of the Children's Basic Health Plan

The Children's Basic Health Plan (CBHP) provides subsidized health insurance for children in low-income families not eligible for Medicaid. CBHP serves as the State's program under the federal Children's Health Insurance Program (CHIP), which was passed by Congress in August 1997. Under CHIP, almost \$40 billion in federal funds was made available over a 10-year period to states with approved plans. Colorado expended approximately \$24.3 million in state and federal funds for CBHP in Fiscal Year 2000. The federal government reimburses about 65 percent of CBHP expenditures that qualify under CHIP laws and regulations.

As of April 30, 2000, Colorado had enrolled 24,410 children in the Children's Basic Health Plan out of an estimated 69,100 eligible in the State. CBHP is available to children in families not qualifying for Medicaid at or below 185 percent of the federal poverty level. Children must be under 19 years of age.

State statutes also establish the CBHP Policy Board (Board), which sets policy and adopts rules for CBHP. The Department of Health Care Policy and Financing (HCPF) administers the program and, as required by statute, contracts for the marketing, outreach, eligibility determination, and enrollment functions of CBHP. Currently the Department contracts with Child Health Advocates (CHA) to perform these functions. CBHP is marketed under the name "Child Health Plan Plus," or "CHP+."

During Fiscal Year 2000 the Office of the State Auditor conducted a performance audit of the Children's Basic Health Plan. The audit comments below were contained in the *Children's Basic Health Plan Performance Audit*, Report No. 1225A, dated July 2000.

Reduce Administrative Costs for CBHP

The organizational structure for the Children's Basic Health Plan involves numerous entities and contractual relationships. We found that the complexity of the administrative structure, combined with the relatively small number of children served and the costs of starting an entirely new program, has contributed to significant administrative costs. Additionally, the State elected to develop a separate administrative structure for CBHP than for the existing Medicaid program. For Fiscal Year 2000, administrative costs for CBHP are expected to run almost 37 percent of the cost of health care services provided to children, or almost 27 percent of total program costs (health care services plus administrative costs). In other words, out of each dollar spent on CBHP, about 27 cents is spent on administration.

On the basis of reports provided by the Department to the federal Health Care Financing Administration (HCFA), since the start of operations in April 1998 through March 2000 CBHP administrative costs averaged about 23 percent of total program costs (i.e., health care services plus administrative costs). The program's administrative costs exceed the limit established by the federal government for the purposes of receiving federal reimbursement for program administration. The limit for allowable administrative costs is based on these costs not exceeding 10 percent of total program costs. To help with start-up costs, HCFA temporarily allowed states to draw federal funds for administration in excess of the limit, with the understanding that ultimately any excess draws would need to be repaid. The Department reports that as of March 31, 2000, the State owed about \$2.9 million to HCFA due to draws above the federal limit for administrative costs.

The Department needs to continue to explore options for reducing administrative costs. The Department identified several options in its Fiscal Year 2001 budget request including changing CBHP to a Medicaid-expansion program, changing CBHP to a combined stand-alone and Medicaid-expansion program, privatizing more CBHP functions, or performing more administrative functions within the Department to reduce redundancy. Another alternative would be to create a stand-alone program that uses the Medicaid administrative structure to the greatest degree possible. This option could allow the State to take advantage of the existing Medicaid infrastructure without creating another entitlement program. (CFDA No. 93.767–State Children's Health Insurance Program–Earmarking.)

Recommendation No. 41:

The Children's Basic Health Plan Policy Board and the Department of Health Care Policy and Financing should identify options for reducing administrative layers and costs for the Children's Basic Health Plan, including options for alternative structures and delivery systems. The Board and the Department should establish a time line for completing this review and submitting recommended statutory changes to the General Assembly on ways to achieve these goals.

Children's Basic Health Plan Policy Board Response:

Agree. The Board agrees that administrative costs are a concern. The Board will review the report and respond to the Legislative Audit Committee by no later than January 1, 2001.

Department of Health Care Policy and Financing Response:

Agree. The Department has continued to identify options for reducing administrative costs. The non-HMO network has been maintained by the Department due to its overall cost-effectiveness to date (in comparison to other options). However, given the advent of new factors that will affect the volume of enrollment in the non-HMO network (HMO service area expansions), and recent federal statements of policy regarding the availability of matching funds, the Department may need to implement another solution for statewide benefit delivery. A major effort has been under way to identify alternatives to the non-HMO network, and proposals will be made to the Legislature this Fiscal Year 2001 in this area. The Department will also evaluate the administrative structure prior to the legislative session and prepare recommended statutory changes by January 1, 2001.

Clarify Requirements Related to Eligibility

Our audit identified some changes that need to be made to the current eligibility rule for CBHP to ensure that documentation requirements for eligibility determination are consistent and appropriate.

- *Social Security Numbers.* Under the CBHP eligibility rule, a child's Social Security Number is required in order for the child to be eligible for and enrolled in the program. However, federal guidance for CHIP states that Social Security Numbers should not be required as a condition of eligibility for state programs.

Department staff state this requirement was made because federal law requires CHIP programs to screen for Medicaid, which does require a Social Security Number, and because federal guidelines also emphasize the need to streamline information requirements among programs. However, the CBHP rule is in conflict with federal guidance, which explicitly prohibits the requirement of a Social Security Number for CHIP enrollment. Federal guidelines contain recommended wording that can be used on applications to make families aware that provision of a Social Security Number for participation in a CHIP program is not required.

- *Alien Resident Identification Number.* If the child is not a U.S. citizen, the CBHP eligibility rule requires that an alien resident identification number be provided. This is consistent with federal guidelines requiring documentation of immigration status. However, according to Child Health Advocates staff, self-declarations are accepted for alien registration numbers and date of entry into the country. CHA's procedures are not consistent with federal guidance or with the CBHP rule requiring documentation of immigration status.
- *Conflicting requirements for income.* The eligibility rule for CBHP states that income has to be verified for income earned "within 30 days of the date of application" (HCPF-CBHP Sec. 130.1.B, C.C.R.). However, in the section regarding the calculation of gross family income for determining eligibility, the rule states that all income received by the family "in the calendar month prior to the date of application" shall be counted (HCPF-CBHP Sec. 150.3, C.C.R.).

These two time periods may not necessarily be the same. Not only is this administratively complex, but it is counter to the main purpose of verifying income: to ensure eligibility determination is based on information that has been substantiated.

These issues should be addressed to ensure that CBHP is in compliance with all documentation requirements and that requirements are consistent. (CFDA No. 93.767–State Children's Health Insurance Program–Eligibility.)

Recommendation No. 42:

The Children's Basic Health Plan Policy Board should revise the Children's Basic Health Plan eligibility rule to:

- a. Reflect federal guidance stating that Social Security Numbers are not to be required as a condition of eligibility for children that apply for the program.
- b. Require verification of income for the same time period used to calculate gross family income for the purpose of eligibility determination.

Children's Basic Health Plan Policy Board Response:

Agree. The Board will review the recommendations in the report and respond to the Legislative Audit committee by no later than September 30, 2000.

Recommendation No. 43:

The Department of Health Care Policy and Financing should ensure enforcement of state and federal requirements that applicants for Children's Basic Health Plan provide documentation of alien registration numbers.

Department of Health Care Policy and Financing Response:

Partially agree. The Department believes that federal guidance surrounding verification of citizenship or national status and of immigration status is conflicting. The Personal Responsibility and Work Opportunity Act of 1996 requires that separate CHIP programs verify citizenship or national status and immigration status. However, a letter received by HCFA regarding new guidance relating to the Immigration and Naturalization Service (INS) states that "Section 1902(a)(7) of the Social Security Act requires States to safeguard information regarding applicants for and recipients of Medicaid benefits and prohibits disclosure of that information to an outside entity unless it is directly connected to the administration of the State plan. We have determined that the INS and State Department public charge determinations would not be connected to the administration of the State plan, unless such determinations will directly assist the State in recovering outstanding debts from an alien (most commonly involving overpayments or fraud).

States are encouraged to adopt similar restrictions under separate CHIP programs." While this letter directly relates to the issue of "public charge," it does specify that disclosure of information to the INS or Department of State is prohibited. It is the Department's understanding that, under the Systematic Alien Verification of Entitlement system (SAVE) used by Medicaid to obtain verification without requiring personal documentation, information is sent to a clearinghouse for verification of alien status. If the information is verifiable, a positive indication is returned to the program requesting the information. If it is not verifiable, the information is turned over to the INS for investigation. If the letter is correct, the existing use of the SAVE system is prohibited by HCFA. However, the Department shall continue to investigate other alternatives of verification. Implementation date: Contingent upon clarification from HCFA.

Prioritize the Accuracy of Payments to Providers

We reviewed the Department's systems for paying HMOs and physicians serving children as primary care physicians (PCPs) under the CBHP Network. We found that HMO payments are not routinely adjusted for retroactive changes to enrollment records, and the reconciliation performed for retroactive changes related to physician payments needs improvement. For example, CHA may learn that a child has been enrolled in the Medicaid program for several months. This will result in a retroactive adjustment to the CBHP enrollment records for those months, and it should also result in a negative adjustment to the next payment to the appropriate provider. However, adequate controls are not in place to ensure retroactive adjustments to enrollment records are identified and necessary adjustments to payments are made.

Overpayments to providers are likely to result from the failure to make retroactive adjustments. During April and May 2000, CHA staff made 61 retroactive disenrollment adjustments that should have resulted in almost \$14,000 in reductions to capitation payments. However, staff reported that information regarding these retroactive adjustments was not relayed to network administration staff at CHA. The network administration staff calculate the amount of capitation payments for HMOs and PCPs and any adjustments to these payments. In another instance an error in enrollment records identified by CHA staff that should have resulted in reduction of about \$1,500 in capitation payments due to an incorrect birth date for a child was not relayed to network administration staff.

In addition to these communication problems within CHA, we found that there are not adequate procedures in place generally to ensure that retroactive enrollment adjustments

are reflected in future payments to providers. For Fiscal Year 2000 the responsibility for identifying these retroactive enrollment adjustments and correcting future payments is as follows:

- C **HMO capitation payments.** The Department is responsible for using information from CHA to identify discrepancies between projected and actual enrollments and making the required adjustments to future capitation payments. However, the Department does not have procedures in place to compare the projected enrollments, used as the basis for monthly payments, with actual enrollments, or to otherwise identify retroactive adjustments that should affect future payments.

CHA staff reported that in February 2000 they provided the Department with an estimate indicating about \$80,300 was overpaid in capitation payments to HMOs over a three-month period early in Fiscal Year 2000. At the conclusion of our audit four months later Department staff indicated they had not ascertained the accuracy of the information or made any necessary adjustments related to this information.

- C **CBHP Network.** CHA network administration staff complete a reconciliation between projected and actual enrollments for the CBHP Network providers; however, the reconciliation is performed quarterly, and as a result, the “look-back” period is only from 30 to 90 days. This means that CHA personnel are unlikely to identify retroactive enrollment adjustments made outside of the 30- to 90-day window and to adjust future payments accordingly.

We believe a more adequate look-back period is at least 120 days. We identified enrollment errors related to CBHP children simultaneously enrolled in Medicaid that were as much as 12 months old (simultaneous enrollment is discussed in the next section of this chapter).

Further, adjustments to capitation payments must be made within a reasonable period of time. The Department’s contracts with HMOs and CBHP Network providers do not permit HCPF to recover for adjustments that are more than six months past. Therefore, in some instances it may be too late for the Department to recover amounts related to retroactive disenrollments.

These retroactive adjustments need to be corrected not only because provider payments should be accurate but, also because the State receives matching funds from the federal government based on these payments. If provider payments are overstated for CBHP, the

Department is also drawing more federal funds than is appropriate under the CHIP program. The Department should take immediate steps to improve controls in this area to ensure funds are spent appropriately. (CFDA No. 93.767–State Children’s Health Insurance Program–Allowable Costs/Cost Principles.)

Recommendation No. 44:

The Department of Health Care Policy and Financing should ensure capitation payments for the Children’s Basic Health Plan are accurate by:

- a. Performing monthly reconciliations for provider payments that compare enrollment records used as the basis of payment with post-payment enrollment records for the previous 120 days. Changes identified should be reflected in future payments to providers.
- b. Requiring appropriate communication among staff to ensure all adjustments to enrollment records are relayed to staff calculating capitation payments.

Department of Health Care Policy and Financing Response:

- a. Agree. Establishment of requirements and procedures to ensure the accurate payment of providers was the Department’s top delivery system-related priority during contract renewal negotiations with the contractor during February and March of this year. In the Fiscal Year 2001 contract, the Department has specified its reconciliation expectations in detail. The Department will implement a *monthly* provider payment reconciliation procedure that will account and adjust for *all* retroactive disenrollments. Implementation date: August 15, 2000.
- b. Agree. The Department has already taken the following actions to address this problem. These are:

Implementation of a series of monthly enrollment reports that provide a definitive statement of HMO enrollment for the purpose of payment and reconciliation. These reports are symmetrically represented in the Department’s contracts with both the contractor and participating HMOs.

Implementation of information system changes at the contractor that will automate the reconciliation of HMO capitation payment. This will reduce opportunity for errors and omissions due to human oversight and miscommunication within the contractor.

Creation of a monthly payment summary report that reflects *all* adjustments for retroactive disenrollments. The amount of capitation adjusted due to retroactive disenrollments will be documented monthly on this summary report, and distributed to both the Department and HMOs. Implementation date: August 1, 2000.

Identify and Correct Duplicate Enrollments in CBHP and the Medicaid Program

CBHP children are sometimes simultaneously enrolled in the Medicaid program (“dual-enrolled”). However, instances of dual enrollment can occur without necessarily being detected by either program. This can occur because eligibility and enrollment for CBHP and Medicaid are tracked through two separate systems. Currently there is no routine exchange of information between the CBHP and Medicaid databases to systematically identify and correct instances of dual enrollment between these programs.

As part of our audit a data match was performed between Medicaid and CBHP enrollment lists for children enrolled in CBHP for part or all of the period from May 1999 through April 2000. Out of 15,691 children enrolled in CBHP during some portion of that year, there were 1,830 children (11.7 percent) enrolled in Medicaid at the same time for some part of the year. Of these dual enrollments, 423 children had been dual-enrolled between 4 and 12 months. These numbers are likely understated because records for 7,370 additional CBHP children enrolled during part or all of this 12-month period could not be matched against the Medicaid system due to data inconsistencies.

Double payment of health care coverage is a poor use of funds, and additionally, these kinds of payments violate federal regulations on two counts:

- C Federal regulations prohibit charging the same expenditure to two different grant programs. In this case the federal CHIP and Medicaid programs are both being charged for the same child for health services for the same period of time.

- C Federal regulations prohibit enrolling a child in the state CHIP program if the child is eligible for Medicaid. Therefore, any corrections in payments must be made in CBHP rather than in the Medicaid program.

Assuming that children are in the pre-enrollment stage of CBHP for about two months, we estimated that approximately \$242,000 in excess CBHP capitation payments were made for dual-enrolled children in the period tested. This estimate is likely to be low because it does not include payments made for specialized services under the CBHP Network. In addition, it does not include any estimate for the 7,370 CBHP children for whom the data match could not be run because of data problems.

In some instances CHA may have made adjustments that corrected some of these overpayments; however, weaknesses in controls over provider payments, discussed in the previous section, suggest that although enrollment records may have been corrected, provider payments may not have been adjusted. In any case, as well as improving controls over provider payments, the Department needs to routinely match information between various systems to ensure instances of dual enrollment are identified and corrected in a timely manner. The fact that some children were dual-enrolled for as much as a year clearly indicates a lack of procedures to ensure dual enrollments are identified and payments corrected. (CFDA No. 93.767–State Children’s Health Insurance Program–Allowable Costs/Cost Principles; Eligibility.)

Recommendation No. 45:

The Department of Health Care Policy and Financing should work with the Department of Human Services to identify on a monthly basis instances in which children are simultaneously enrolled in the Children’s Basic Health Plan and in the Medicaid program. Erroneous enrollment records and provider payments should be corrected in a timely manner.

Department of Health Care Policy and Financing Response:

Agree. The Department appreciates the work that the Office of the State Auditor has done in this area. The Department will continue to work with the Department of Human Services to attempt to resolve these cases in the shortest amount of time possible.

The statutory design of the Children’s Basic Health Plan program reflects a model common to commercially insured groups (i.e., prospective health plan enrollment and 12-months’ continuous eligibility). However, given the recent statutory change that explicitly allows retroactive CBHP eligibility and the fact that Medicaid eligibility is

mutually exclusive to CBHP eligibility, the Department may be compelled to implement the complex enrollment status and payment reconciliation procedures that were formerly unique to the Medicaid managed care program. This may have an impact on HMO participation and, potentially, rates.

Reconciliation of Fiscal Year 2000 CBHP files identified as having overlapping Medicaid eligibility spans and payments to participating HMOs and providers will be a very labor-intensive effort that will require coordinated work within five (5) entities: the Department, the contractor, Anthem, Horizon Behavioral Services, and Consultec (the Medicaid fiscal agent). Failure of these entities to coordinate retroactive edits of eligibility and enrollment status and process CBHP-to-Medicaid payment reconciliations accurately (most of which will need to be completed manually) will have a *significant adverse impact* on HMOs and providers participating in both programs.

In addition to the operational issues identified above, CBHP-to-Medicaid payment reconciliation for participating HMOs will *not* be possible unless there is a change to Medicaid HMO enrollment rules. Unlike CBHP, Medicaid HMO enrollment rules are very complex and prescriptive. A CBHP applicant's selection of an HMO must be deemed in the rules as an acceptable choice for the purpose of Medicaid enrollment. Failure to implement such a change to the Medicaid enrollment rules will: (A) prohibit the Department from maintaining a child's enrollment in his or her original CBHP plan, (B) result in a significant financial loss to the HMO, and (C) potentially impede continuity of care.

Implementation date: September 15, 2000.

Improve Premium Administration

The Department's administrative contractor for CBHP, Child Health Advocates, is responsible for charging and collecting monthly family premiums and maintaining, reconciling, and transferring premium information to the State. As of April 2000, CHA reports indicate about 9,100 families, or 70 percent of the almost 13,000 families enrolled in CBHP, are charged premiums, and the State had recorded fiscal year-to-date premium revenues of a little over \$1.3 million. CHA reported about \$457,200 was outstanding as premiums due from families.

Problems with premium accounts include:

- Because of inaccurate premium records maintained by the prior program administrator for CBHP, the Department allowed CHA to “archive” all amounts due from families as of February 28, 1999. In other words, families were not specifically requested to pay these amounts due to the program. The archived amount represented almost \$292,600; to date, HCPF reports that about \$67,500 of the amount remains outstanding.
- In the fall of 1999, the Department asked CHA to reconcile each policyholder’s account. CHA staff subsequently performed a detailed review of individual premium accounts during which adjustments were made to over 3,300 families’ accounts, or approximately 38 percent of premium-paying families at that time. In some cases staff did not detail the basis for these changes. Further, for some accounts, staff deleted premium charges from records altogether.

In other words, CHA staff had the ability to delete activity from families’ accounts, and the information system did not maintain evidence of the original entries or the dollar amounts deleted. CHA staff also reported that due to the volume of adjustments, not all adjustments were reviewed by a supervisor. Because of the risk of errors and irregularities, write-offs and deletions are a highly sensitive area that should have been tightly controlled, especially in view of system deficiencies.

- We found that a basic reconciliation between individual premium account balances and total premiums due had not been done. This reconciliation ensures that all premiums charged, adjustments made, and payments received are posted to families’ individual accounts. CHA staff report that they perform a “reasonability check” on the overall balance, and they provided us with a spreadsheet identifying differences between the calculated premium receivable balance and the balance generated by the information system. These differences ranged from about \$570 to over \$37,600 from month to month over the past ten months. CHA staff reported they were unable to determine the reasons for these differences and make corrections to individual accounts that might have been needed.
- We also identified a lack of adequate segregation of duties. One staff person makes the bank deposit, enters adjustments to individual accounts, and performs the monthly bank reconciliation. This combination of duties means that funds could be misappropriated and the action subsequently concealed. CHA staff indicated that beginning in July 2000 they will utilize a bank lock-box for premium payments, significantly lessening the number of cash receipts to which CHA staff have access. Despite this improvement, adequate segregation of duties should be maintained at CHA.

Problems With the Premium Collection System Affect Individual Family Accounts

We reviewed a sample of 67 families' premium accounts. We identified problems in 14 accounts (about 21 percent):

- C *Premiums not charged appropriately.* In three accounts families were not charged premiums for a month when they should have been. These same families were charged a premium for a month in which they should not have been.
- *Premiums not charged in a timely manner.* In March 2000, premiums for 11 families' accounts were charged for months as far back as October 1999.

Charging for premiums should be a relatively straightforward process. The number of errors in the sample indicates a lack of adequate systems and controls to ensure ongoing accuracy of accounts.

In addition to the problems noted with premium tracking and collections, inadequacies of the present information system used by CHA likely contributed to some concerns identified in the audit. We noted that the system is not able to perform monthly "cutoffs"; as a result, adjustments to prior accounting periods can and are being made on a continual basis. We also found that the detailed premium receivables report generated from the system showed individual account balances not in agreement with balances in the individual account records within the system.

Regardless of the source of the problems found in the audit, all must be addressed. Under the cost sharing rule for CBHP scheduled to go into effect on August 1, 2000, families will be disenrolled from the Children's Basic Health Plan based on nonpayment of premiums. Staff indicate past due amounts as of July 31, 2000, will not be used as a basis for disenrollment. However, it is imperative that families' account balances are accurate and reliable under the new rule; otherwise, the State risks disenrolling families on the basis of erroneous information. (CFDA No. 93.767–State Children's Health Insurance Program–Program Income; Reporting.)

Recommendation No. 46:

The Department of Health Care Policy and Financing should ensure that the contractor for the Children's Basic Health Plan has adequate controls over premium administration by stating

expectations clearly in the contract and monitoring compliance. Controls over premium administration should include:

- a. Documenting staff responsibilities for all aspects of premium administration, including supervisory review and limitations on authority.
- b. Maintaining adequate supporting documentation for all adjustments made to families' accounts. Such support should include at a minimum explanations for the adjustment, date of the adjustment, individual entering the adjustment, and evidence of supervisory review and approval.
- c. Completing a monthly reconciliation between individual family account balances and the total premium accounts receivable balance. The sources of discrepancies should be identified and resolved, including appropriate adjustments to individual family accounts.
- d. Establishing appropriate segregation of duties over cash receipts.

Department of Health Care Policy and Financing Response:

Agree. The Department is requiring the contractor to correct all of the identified deficiencies, as part of the Fiscal Year 2000 contract closeout. No final payment for the Fiscal Year 2000 contract will be made until full resolution is documented by the contractor and accepted by the Department. Premium information system modifications have been made and will be implemented concurrent with the implementation of the new premium compliance (cost sharing) rule. Segregation of duties over cash receipts has been implemented. Payment for Fiscal Year 2001 contract year will be made only for accurate, timely and procedurally acceptable premium administration performance.

Implementation date: part "a," June 30, 2000; part "b," June 20, 2000; part "c," August 1, 2000, and ongoing; and part "d," June 20, 2000.

Recommendation No. 47:

The Department of Health Care Policy and Financing should ensure that the new information system for the Children's Basic Health Plan premium administration is adequate to meet program requirements and addresses problems with the present system. This includes, but is not limited to, ensuring that:

- a. Transactions entered in the system cannot be subsequently altered or deleted.
- b. Monthly and year-end cutoffs can be performed for accounting and reporting purposes.
- c. Reports generated by the system produce information consistent with underlying data in the system.

Department of Health Care Policy and Financing Response:

Agree. Premium information system modifications that were under way at the time of the audit, which are designed to support fully accountable premium administration operations (and that will also resolve the audit's information systems issues in a prospective sense), will be completed and installed by August 1, 2000, concurrent with the implementation of the new premium compliance rule. As of mid-July, testing by the Department of the developed system components has been fully satisfactory.

The Department assures that all components of the corrective action process noted above are fully and effectively implemented and maintained, and the Department will pay only for acceptable premium administration performance.

Ensure Federal Requirements for CHIP Are Met

Under the federal Single Audit Act, the Department is responsible for compliance with requirements for the federal Children's Health Insurance Program, or CHIP. This means that HCPF must have adequate measures to ensure that CHA and other contractors meet these requirements. This is particularly important in the case of CHA, since it is responsible for critical functions of the Children's Basic Health Plan such as eligibility determination. Out of Fiscal Year 2000 year-to-date expenditures of \$18.5 million for CBHP as of April 30, 2000, we estimated that CHA directly or indirectly controlled the expenditure of \$18.08 million (about 98 percent).

One way for the Department to determine CHA's compliance with federal requirements would be for HCPF to classify CHA as a subrecipient for federal award reporting purposes. Classifying CHA in such a manner would require it to have an annual audit under the Single Audit Act. This type of audit must determine if an entity has adequate controls in place to ensure federal funds received are expended in accordance with applicable federal laws and

requirements. By requiring such an audit, the Department would receive an independent assessment of CHA's controls and compliance relative to federal requirements under CHIP.

Another way for the Department to determine if CHA is meeting federal requirements is for HCPF to perform on-site monitoring of CHA operations. Colorado state agencies operating federal programs of comparable size to CHIP typically have established some means of on-site monitoring of subrecipients, in addition to requiring the annual audit under the Single Audit Act. In any case, the Department must implement measures to ensure funds are spent appropriately. (CFDA No. 93.767–State Children's Health Insurance Program–Subrecipient Monitoring.)

Recommendation No. 48:

The Department of Health Care Policy and Financing should develop and implement a mechanism to ensure the administrative contractor for the Children's Basic Health Plan complies with federal requirements.

Department of Health Care Policy and Financing Response:

Agree. The Department, as part of the Fiscal Year 2000 contract closeout, is requiring the contractor to agree in writing to comply with federal Single Audit procedures, beginning with an audit of the Fiscal Year 2000 contract year. Final payment to the contractor for Fiscal Year 2000 will not be made until this agreement is provided to the Department. The Department is also reviewing its staffing and organizational priorities to determine if modifications to its contract management procedures (including on-site monitoring procedures) are needed and feasible.

Address Processing Delays Between CBHP and Medicaid

Lack of adequate communication between CBHP and Medicaid eligibility systems can cause processing delays for applicants referred to the other program. In mid-February 2000, CHA began to formally track the length of time it takes to receive information back on applicants referred to the county departments of social services. From mid-February to mid-March 2000, Child Health Advocates sent the counties applications for 536 children who appeared

Medicaid-eligible. By late April, CHA had received dispositions from the counties for only 144 of the children, or about 27 percent of the total. For the remaining 392 children (73 percent), we tested a sample of 27 applicants and were only able to determine that 15 of these had been enrolled in Medicaid.

Overall, for the first ten months of Fiscal Year 2000, CHA reports that 5,353 applicants were referred to the counties, or about 14 percent of applicants. As of the end of April 2000, CHA had received dispositions on 1,252 children. Staff report there can be substantial delays in hearing back from the counties, and in some cases the disposition is never received.

Feedback from the counties is important because CHA needs to follow up with families concerning children determined ineligible for Medicaid. These are likely to be children who could be enrolled in CBHP. Out of the 1,252 applicants for whom CHA had received information back from the counties, 395 children (32 percent) had been denied Medicaid. This suggests that a substantial number of applicants referred to the counties may ultimately end up being eligible for CBHP.

There are several ways in which the Department could address these delays:

- T Place Medicaid eligibility technicians at Child Health Advocates. This is the most straightforward solution from the viewpoint of processing these potentially Medicaid-eligible children in the quickest manner. This would require a change in the state law requiring county departments of social services to determine Medicaid eligibility. However, discussions are already under way to change this law in order for the proposed Colorado Benefits Management System to be effective as a single entry point system.
- T Arrange in larger counties for Medicaid eligibility technicians to spend some portion of time on a weekly basis at one of the satellite eligibility determination (SED) sites for CBHP. This would require that access to the Medicaid eligibility system be made available at these sites. This type of arrangement is currently in place at one of the SED sites in Denver.
- T Establish specific time frames for counties to report on the status of applicants to CBHP. In cases where a disposition has not occurred, require an explanation of the nature of the delay. This would require the least change in the current process and probably be the least effective in reducing time frames.

Additionally, CHA reports that applications originating with the counties are not necessarily forwarded in a timely manner, although CHA does not formally track these delays. During the first ten months of Fiscal Year 2000, almost 7,000 applicants, or nearly 18 percent, came

through county departments of social services. To expedite these applications, SED sites could be required to pick up applications from the counties on a weekly basis.

The Department should ensure that the exchange of applications and eligibility information between CBHP and the Medicaid program occurs in a timely manner. This will reduce excessive delays in processing time that could discourage families from participating in the programs and also could cause families to delay needed medical care for their children. (CFDA No. 93.767–State Children’s Health Insurance Program–Eligibility.)

Recommendation No. 49:

The Department of Health Care Policy and Financing should ensure applications referred between the Children’s Basic Health Plan and Medicaid program are processed timely. Options include:

- C Locating Medicaid eligibility technicians at eligibility sites for the Children’s Basic Health Plan.
- C Requiring satellite eligibility determination sites for the Children’s Basic Health Plan to collect referred applications from the county departments of social services on a regular basis.
- C Establishing specific time frames for counties to report on the status of applicants to Children’s Basic Health Plan and on the nature of any delays.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that a system that allows more timely determination of Medicaid eligibility would benefit applicants to both Medicaid and CBHP. The Medicaid eligibility system is devolved to the counties. Placing Medicaid eligibility technicians at Child Health Advocates would require statutory change. Placing Medicaid eligibility technicians at SED sites has received limited support from the counties (other than Denver) because of volume issues. To date, counties have not found this recommendation to be cost-effective. We will continue to meet with counties to discuss the possibility of this option. The Department has been working with the counties and plans to issue an agency letter to the county departments of social services by September 30, 2000, that will specifically address referral of applications between CBHP and Medicaid, as well as other communications and

procedural issues. The Department will continue to stress the need for timely referrals in future meetings with the counties.

CBHP Network Claims Audit

As part of our audit of the Children's Basic Health Plan the Office of the State Auditor contracted with Buck Consultants to evaluate the payment of health insurance claims under the program. Children living in areas of the State not covered by HMOs participating in CBHP receive health care services through the CBHP Network (Network). Designated physicians in the Network serve as Primary Care Physicians (PCPs) and as gatekeepers for referrals to other services (e.g., ancillary and specialty services, hospital services) that are paid on a fee-for-service basis.

The following is an audit comment on claims paid through the Network from the report prepared by Buck Consultants (*Children's Basic Health Plan Claims Audit*, Report No. 1225B).

Resolve and Prevent Conflicts in Eligibility Information

During our review we noted that CHA forwards eligibility information, such as additions, deletions, and changes, to Anthem on a regular basis. Under the CBHP Network, Anthem (formerly Blue Cross Blue Shield of Colorado) is responsible for processing claims payments to providers. However, we found there is no reconciliation between the eligibility information maintained by CHA and by Anthem.

Eligibility File Reconciliation

As an integral part of our review, we compared the CHA and Anthem eligibility files. A sample of files for 20 families was compared with eligibility information maintained at Anthem for these same families. We found discrepancies in 4 out of the 20 families tested (20 percent); these families involved a total of nine children. The following discrepancies were noted:

- C For seven children, Anthem and CHA had different termination dates on file. For six children, Anthem had later termination dates on file than CHA, which could result in claims being erroneously paid by Anthem. For the other child, Anthem had an earlier termination date than CHA, which could result in claims being erroneously denied by

Anthem. In all instances, CHA stated it had previously communicated the corrected termination dates to Anthem.

- c For two children, Anthem had no eligibility files, while CHA had both children listed as currently enrolled. This could have resulted in claims being erroneously denied by Anthem if CHA's records are accurate and the children are enrolled.

(CFDA No. 93.767–State Children's Health Insurance Program–Eligibility.)

Recommendation No. 50:

The Department of Health Care Policy and Financing should ensure that consistent and accurate eligibility data for the Children's Basic Health Plan are reflected on-line at Anthem and Child Health Advocates by:

- a. Requiring that eligibility discrepancies identified during the claims audit and any resulting claims issues are resolved.
- b. Establishing a reconciliation process on eligibility data to be performed by Anthem and Child Health Advocates on a monthly basis.

Department of Health Care Policy and Financing Response:

Agree. The Department has established formal processes in the Fiscal Year 2001 Anthem and Child Health Advocates agreements for adherence to a prioritized work agenda and corrective action plans. Monthly eligibility reconciliation procedures are being prioritized and implemented. Implementation date: October 1, 2000.

Department of Higher Education

Introduction

The Department of Higher Education was established under Section 24-1-114, C.R.S., and includes all public education institutions in the State. It also includes the Auraria Higher Education Center, the Colorado Commission on Higher Education, the Colorado Council on the Arts, the Colorado Student Loan Division, the Colorado Historical Society, and the Division of Private Occupational Schools. Please refer to page 47 in the Financial Statement Findings section for additional background information.

Board of Regents of the University of Colorado - University of Colorado

The University of Colorado was established on November 7, 1861, and its current governing authority is the Board of Regents. The Board of Regents is constitutionally charged with the general supervision of the University's four campuses.

The following comments were prepared by the public accounting firm of KPMG LLP, who performed work at the University of Colorado.

Processes for Fixed Assets Records Maintenance at the University of Colorado at Colorado Springs Should Be Improved

The University of Colorado at Colorado Springs (UCCS) owns numerous equipment items ranging from computers to research equipment, which are tracked in a campus-developed fixed asset system. We noted that the UCCS did not maintain accurate and complete capital equipment records. Specifically, records could not be located supporting assets that were disposed of in Fiscal Year 2000. Please refer to Recommendation No. 6 in the Financial Statement Findings section for additional details, our recommendation, and the University's response.

Processes Should Be Strengthened to Ensure Allowable Costs Are Charged to Grants at the University of Colorado at Boulder

The University of Colorado at Boulder (UCB) receives approximately \$176 million of federal research and development funds each year. Such funds are primarily spent on payroll and benefits, operating and capital expenses and indirect costs. Costs charged to federal grants are controlled and monitored by the principal investigator and his/her staff on the grant as well as the Office of Contracts and Grants and the Sponsored Projects Accounting Office.

For payroll reporting, when individuals are assigned to work on a federally sponsored research and development grant or contract, their status as full-time or part-time is documented and their salary is denoted on a Personnel Action Form, which also denotes position and account(s) to be charged. This Form remains in effect until a change is made (i.e., termination, change of status, transfer, promotion). Each payroll period, employees certify, through a Personal Effort Report, the percentage of time actually devoted to the project. If this percentage differs by more than 5 percent of the percentage stated on the Personnel Action Form, the employee must state whether this is expected to be a permanent change in time and effort devoted to the project and, if so, whether a corrected Personnel Action Form, reflecting the change, has been processed.

We tested 15 research and development expenditures at the UCB, 7 of which were payroll and benefits. We noted one exception in our testwork in which an individual was overpaid approximately \$6,800 over a period of three months. Prior to March 1, 2000, the employee worked full-time for the UCB on a National Science Foundation (NSF) grant, CFDA No. 47.049, within the Center for Spoken Language Research. On March 1, 2000, the employee was reduced to part-time status (51 percent). However, the employee continued to receive his full-time salary. This error resulted from incorrect completion of the Personnel Action Form by a new employee. The NSF employee subsequently left employment of the UCB in June 2000. The overpayment was not detected by the University until July 2000. As a result, the federal research grant was overcharged \$6,800.

In order to ensure allowable costs are charged to grants, the UCB should ensure appropriate training is provided to new employees, a detailed review of transactions is completed, and grant budgets are routinely monitored within the Center for Spoken Language Research.

Recommendation No. 51:

The University of Colorado at Boulder should strengthen its processes to ensure allowable costs are charged to grants within the Center for Spoken Language Research.

University of Colorado Response:

Agree. UCB's Accounting and Budget Services department will work with the Center for Spoken Language Research to ensure that only allowable costs are charged to its grants. This will be completed by March 2001.

Internal Control Over Federally Funded Fixed Asset Disposals Can Be Improved at the Boulder Campus

The UCB Property Services is responsible for disposition of capital equipment. The UCB policy regarding disposals states that a department must obtain Office of Contracts and Grants (OCG) approval for federally funded capital assets. This policy is designed to ensure that equipment is disposed of in accordance with applicable federal and grant regulations. As noted in the policy, it is the department's responsibility to obtain OCG authorization. However, there are certain instances where proper authorization may not be obtained by the department; therefore, it is important that Property Services also ensure that proper authorization is obtained prior to disposition.

We noted in a sample of six disposals of federally funded equipment, two were not properly approved by the OCG. These assets were disposed of in compliance with applicable federal regulations; however, there is an increased risk that disposals may not be in accordance with these regulations if appropriate OCG authorization is not obtained.

The UCB Property Services, OCG, and campus departments should strengthen their processes for disposals of federally funded equipment to ensure that proper authorization is obtained in accordance with UCB policy.

Recommendation No. 52:

The University of Colorado at Boulder should ensure proper authorization is obtained prior to disposition of federally funded equipment.

University of Colorado Response:

Agree. UCB's Accounting and Budget Services, Office of Contracts and Grants, and Property Services will review the UCB property disposition procedures to determine what improvements can be made to ensure proper authorization is obtained prior to disposition of federally-funded equipment. This will be implemented by June 2001.

State Board of Agriculture

The State Board of Agriculture has control and supervision of three distinct institutions: Colorado State University – a land grant university; Fort Lewis College – a liberal arts college; and the University of Southern Colorado – a regional university with a polytechnic emphasis. The Board is also responsible for the Colorado State University Agricultural Experiment Station, the Cooperative Extension Service, and the Colorado State Forest Service.

The Board administers the State Board of Agriculture Fund located at the State Treasury. The Board is authorized to fix tuition, pay expenses, and hire officials. The chief academic and administrative officers are the Chancellor of the Colorado State University System and the President of each institution.

Colorado State University System

Colorado State University, Fort Lewis College, and the University of Southern Colorado have been consolidated as a single financial reporting entity—the Colorado State University System (CSUS).

University of Southern Colorado

The University of Southern Colorado is established by 23-55-101, C.R.S., as a general baccalaureate and polytechnic institution with moderately selective admission standards.

The emphasis of the University of Southern Colorado is on polytechnic education and maintaining strong programs in the liberal arts.

The following comment was prepared by the public accounting firm Grant Thornton LLP, who performed audit work at the University of Southern Colorado.

Improve Documentation and Controls Over the Federal Perkins Loan Program

Federal Perkins loans are available to certain students meeting eligibility requirements established by the United States Department of Education. The loan program is partially funded by the Department of Education. The Department of Education requires certain procedures to be followed by all institutions accepting federal Perkins Loan Program dollars, such as keeping certain documentation in individual files for each borrower. If these procedures are not followed, the University risks losing these federal funds to support student attendance. Our audit procedures included testing ten borrowers who went into repayment during the year and ten borrowers who went into default. We noted the following:

- For three borrowers who went into repayment during the year and one borrower who went into default, the University did not follow required procedures to make sure the borrower receives exit interview information and returns a signed statement with collection information and a copy of their repayment plan to the University.
- For one borrower who went into repayment during the year, the University did not obtain the borrower's signature on the statement with collection information that is required to be returned as part of the exit interview process.
- For one borrower who went into default, the federal Perkins loan promissary note that was signed by the borrower did not contain a stated amount of the loan.
- For one borrower who went into default, no exit interview information had ever been sent to the borrower.

Appropriate documentation should exist to demonstrate compliance with the Department of Education in order to ensure future participation in the federal Perkins Loan Program and to assist in future collection efforts to avoid default by borrowers.

The University of Southern Colorado tracks information related to federal Perkins loans receivable by using a database software system called Greentree to support the summarized activity and balances presented in the University's general ledger system. The Greentree system is a database with accounts for each federal Perkins loan disbursed. The status of the borrowers, payment history, and borrower information are all tracked by the system. The total federal Perkins loan receivable balance as reported by the Greentree system at June 30, 2000, of \$4,320,262, could not be reconciled to the balance as presented on the University's general ledger system at June 30, 2000, of \$4,083,117. The unreconciled difference is \$237,145.

Recommendation No. 53:

The University of Southern Colorado should:

- a. Implement procedures to ensure that all documentation required by the Department of Education is included in the borrower's federal Perkins loan file or that attempts to obtain the required documentation are appropriately documented in the borrower's Federal Perkins loan file. Additionally, the University should also implement review procedures to ensure that all documentation is accurately completed and signed as required by the Department of Education regulations.
- b. Perform a detailed review of the federal Perkins Loan Program database (Greentree) and make appropriate changes and corrections to get the Greentree system in agreement with the general ledger. Due to the age and instability of the Greentree system, the University should also consider changing to a new and more reliable database system or outsourcing the database administration and collection function for federal Perkins loans to a third party.

University of Southern Colorado Response:

- a. Agree. The University has taken initial steps to ensure that documentation in borrower files is complete and accurate. The University will investigate additional measures (i.e., check-off list) that will improve the University's responsibility toward borrower file documentation.
 - b. Agree. The University will take the necessary steps to ensure that our Perkins subsidiary database is reconciled to the University's general ledger. With regard to concerns over the integrity of our subsidiary system, the University is currently evaluating its options.
-

Trustees of the State Colleges of Colorado

The Board of Trustees oversees the four state colleges and the Graduate Center. Please refer to page 50 in the Financial Statement Findings section for additional background information.

Metropolitan State College of Denver

Metropolitan State College of Denver serves a student population in the greater metro Denver area. Please refer to page 50 in the Financial Statement Findings section for additional background information. The following comment and recommendation was prepared by the public accounting firm of Kundinger and Associates, P. C., who completed audit work at Metropolitan State College of Denver.

Improve Procedures Over Monitoring Grant Expenditures

We noted that Metropolitan State College of Denver overcharged a grant during the year ended June 30, 2000. The overcharge related to salaries and benefits and was subsequently identified by the pass-through entity. It will be corrected by reducing future charges to the grant in the amount of the overcharge. Please refer to Recommendation No. 7 in the Financial Statement Findings section for additional details, our recommendation, and the College's response.

Western State College

Western State College is an undergraduate college of liberal arts and sciences. Please refer to page 51 in the Financial Statement Findings section for additional background information. The following comment and recommendation was prepared by the public accounting firm of Chadwick, Steinkirchner, Davis & Co, P.C., who performed audit work at Western State College.

Reconciliation of Work-Study Payments

During our testing we noted that the amount of federal and Colorado work-study funds disbursed and posted through the payroll system are not reconciled to those posted to each student on the financial aid system. Efforts by the College to reconcile a difference

identified resulted in the return of funds to the federal programs. Please refer to Recommendation No. 8 in the Financial Statement Findings section for additional details, our recommendation, and the College's response.

Trustees of the Colorado School of Mines

The Board of Trustees is the governing body of the Colorado School of Mines and is composed of seven members appointed by the Governor, with consent of the Senate, for four-year terms; and one nonvoting student member elected by the student body.

Colorado School of Mines

The Colorado School of Mines was founded on February 9, 1874. The primary emphasis of the Colorado School of Mines is engineering, science education, and research. The authority under which the School operates is Article 40 of Title 23, C.R.S.

The following comments and recommendations were prepared by the public accounting firm of Baird, Kurtz, and Dobson, who performed audit work at the Colorado School of Mines.

Receipt and Use of Federal Funds

The University participates in numerous federal grant programs throughout the year. These grants are largely for the research and development programs within the University and for student financial aid. Research and development and student financial aid were tested as major programs under the *Office of Management and Budget (OMB) Circular A-133* for the year ended June 30, 2000. During the year the University had expenditures under these federal grants of \$14.8 million. Our testing noted instances of noncompliance with the requirements of federal grants or OMB Circular A-133 as follows.

Improve Subrecipient Monitoring

In the fiscal year ending June 30, 2000, the University reported on its Schedule of Federal Assistance funds passed through to subrecipients of \$2,871,709 in ten programs.

The requirements set forth in the *OMB Circular A-133* provide that pass-through entities (in this case the University) obtain reasonable assurance that federal award information and compliance requirements are identified to subrecipients, subrecipient activities are

monitored, subrecipient audit findings are resolved, and the impact of any subrecipient noncompliance on the pass-through entity is evaluated. Also, the pass-through entity should perform procedures to provide reasonable assurance that the subrecipient obtains required audits and takes appropriate corrective action on audit findings. During our testing of research and development grants we found that the University did not adequately document information about its subrecipient monitoring.

The University designates a principal investigator, usually a University professor. This investigator is responsible for approving all expenditures submitted by subrecipients and for supervision of the subrecipient. While proper supervision may be occurring, the University did not provide us with documentation to support the monitoring process. Without the documentation, we could not determine if all federal requirements had been met.

This recommendation affects the following grants: 10.43-3AES-6-80075, 35107-4412, 12.F49620-98-1-0483, 81.KH800022MW, 93.5 R01-ES06825-02, 66.502, 66.R 826651-01-0, 43.NCCW-0096, 43.NAG3-1970, and 43.TASK ORDER RF-323.

Recommendation No. 54:

The Colorado School of Mines should develop subrecipient monitoring documentation policies and procedures to help ensure that subrecipient files are properly maintained and provide documentation for the monitoring that has occurred.

Colorado School of Mines Response:

Agree. Policies and practices, at both the departmental and institutional level, for documentation of subrecipient monitoring, will be strengthened.

Establish and Document a Consistent Policy for Determining Satisfactory Academic Progress

The granting of federal and state Student Financial Aid is dependent on the student maintaining satisfactory academic progress. Federal requirements state that the University's policy must include both a qualitative measure (such as the use of cumulative grade point average) and a quantitative measure (such as a maximum time frame for completion) of the student progress. In reviewing the University's policy for determining

satisfactory academic progress we noted that there are conflicting policies. The Institutional Financial Aid Program Policies manual does not address the cumulative grade point average (GPA). The policy only addresses the current semester's GPA. There is a separate policy in the School's *Undergraduate Bulletin* where a 2.0 cumulative GPA is addressed. In our sample, we determined the policy requiring a cumulative 2.0 GPA was being followed.

Recommendation No. 55:

The Colorado School of Mines should establish and document a consistent policy for satisfactory academic progress to include a cumulative GPA requirement to help ensure students are making progress toward, and will be eligible for, graduation.

Colorado School of Mines Response:

Agree. The finding is accepted. In the past, inconsistent versions of the Satisfactory Academic Progress policy were contained in different publications. As of November 2000, all of the Financial Aid Office publications have been updated and made consistent with regard to the satisfactory progress requirement that a student achieve a 2.000 GPA by the end of their second year of enrollment. If a student does not meet this qualification, the student will be given one academic year in which to raise the cumulative GPA to the minimum level. If the student does not achieve this, further financial aid eligibility will be terminated, subject to the appeals procedures as specified in the Policy.

Improve Process for Notification and Counseling of Students Who Are First-Time Borrowers or Leave School

Under the Federal Family Education Loan (FFEL) program, the University is required to complete and return within 30 days the student status confirmation reports sent by guaranty agencies. Unless the University expects to complete its student status report within 60 days, the University must notify the lender or guaranty agency within 30 days if it discovers that a student who received a loan either did not enroll or ceased to be enrolled on at least a half-time basis. During our testing the University represented this notification occurred automatically, but there was no documentation the lenders and guarantors had been

notified. In addition, the University is required to conduct counseling sessions for these students and for students who are borrowing funds for the first time under the Federal Family Education Loan Program (FFEL). In our testing, 11 students of the 30 students selected lacked documentation of the entrance/exit counseling session.

Recommendation No. 56:

The Colorado School of Mines should develop policies and procedures to help ensure proper documentation of notification to lenders and documentation that counseling sessions are performed for students borrowing for the first time and students leaving school.

Colorado School of Mines Response:

Agree. The procedure for notifying lenders of a student leaving school has been changed to include documentation, either electronic or paper, of that notification within 30 days of the Financial Aid Office learning of the student's departure, as required by federal regulations. Such notification is currently done, but documentation is not always consistently maintained.

Loan entrance counseling is required of all first-year first-time borrowers at the School, as required by federal regulations. Loans are not disbursed through the Student Information System (SIS) unless a loan entrance counseling flag has been set to "yes." This is set after we receive our confirmation that the student has completed this procedure, and we have been notified either by paper or electronic format.

Better Documentation of Student Financial Aid Files

We noted during our testing of the Student Financial Aid (SFA) files that the information maintained in the files was inconsistent. In our sample, all required information was ultimately obtained. However, in reviewing the student files, we noted some forms and documentation would be included in one file but excluded from another. Also, certain files did not have the most current calculated need worksheet. While the calculated need was properly updated on the Student Information System (SIS), the files were not updated and thus gave the appearance that certain students received awards in excess of need. Having consistent and immediately available documentation either in a paper or electronic file is the best means of supporting student aid packaging decisions.

Recommendation No. 57:

The Colorado School of Mines should develop a checklist regarding the electronic and written documentation required to be maintained on each student receiving aid to help ensure adequate support is maintained regarding eligibility and aid award decisions.

Colorado School of Mines Response:

Agree. The policies and procedures have been revised to more completely describe the ways in which student files are documented. The first award to a student which consists of a scholarship only is entered directly into the computer system, without a paper worksheet. Need-based awards are always done on paper for the first award. For any adjustments following the first award, counselors are instructed to use the electronic records primarily, unless there is a professional judgement or other major issue involved, which would be more appropriately documented on paper in the student's file.

Department of Human Services

Introduction

The Department of Human Services supervises the administration of the State's public assistance and welfare programs in addition to operating a number of facilities that provide direct services. Please refer to page 57 in the Financial Statement Findings section for additional background information.

Improve Food Stamp Management Evaluation Review Process

In Fiscal Year 2000 the Department provided over \$130.2 million in benefits to eligible households under the federal Food Stamp program and expended approximately \$39.6 million for the administration (CFDA #10.551– Food Stamps; CFDA #10.561–State Administrative Matching Grants for Food Stamp Program). The Food Stamp program is designed to help low-income households buy food. Eligible families are provided with Electronic Benefit Transfer (EBT) cards that can be used to purchase food at participating grocery stores through the use of point-of-sale terminals. The Food Stamp program is overseen by the Department's Food Assistance Programs Division within its Office of Self-Sufficiency. It is administered locally by the county departments of social services.

To ensure that Food Stamp benefit payments are appropriate, federal regulations require states to have an effective system in place for monitoring the Food Stamp program and ensuring that benefits are administered appropriately. Federal regulations have also placed oversight responsibility for EBT card controls under the Food Stamp program. In Colorado, EBT cards can be used to access Food Stamp benefits as well as benefits and payments for other federal and state programs, including Temporary Assistance to Needy Families (CFDA #93.558), Low-Income Energy Assistance Program (CFDA #93.568), Title IV-E Foster Care (CFDA #93.658), Title IV-E Adoption Assistance (CFDA #93.659), Old Age Pension, Aid to the Needy Disabled, and Aid to the Blind.

We identified problems with the Department's Food Stamp monitoring system, most notably in relation to the Department's oversight of the Denver County Department of Social Services. This is of particular concern because Denver County administers the

Food Stamp program for a significant portion of recipients in the State. For example, in Fiscal Year 2000 the Denver office administered food stamp benefits to about 24 percent of the over 1.9 million recipients in the State's Food Stamp program. We discuss these monitoring problems below:

C **The Department has not ensured that significant deficiencies related to EBT cards are corrected on a timely basis.** An audit performed by the Office of the State Auditor on the Electronic Benefit Transfer Service dated August 1998 (*Performance Audit of the Colorado Department of Human Services Electronic Benefit Transfer Service*, Report No.1112) found that several local Food Stamp offices in Denver County had returned over 3,600 EBT cards believed to be damaged to the central Denver County Food Stamps office for destruction. The audit reported several concerns, including:

- < The cards had not been destroyed, although state and federal regulations require counties to routinely destroy damaged or returned cards.
- < The cards were being stored in an unsecured box in a vault in the accounting area, which was accessible to a variety of staff at the Denver office.
- < The cards had not been forwarded by issuance staff at Denver County satellite offices to the central Denver County Food Stamps office with required inventory logs. These logs are used to record the card number, whether or not the card was deactivated, and the staff person returning the card. Therefore, central office staff were unable to determine that information.

This situation presented a clear risk that cards could be improperly used and benefits misappropriated because there was no inventory establishing the number of cards received, no record of whether or not the cards were still activated, and the cards were not stored in a secure location. The Department agreed with the recommendation to address these deficiencies.

In our Fiscal Year 2000 audit we found that in May 1999 and August 2000 the Department's monitoring staff had conducted on-site visits to the central Denver Food Stamps office and noted that the returned cards still had not been destroyed or inventoried and continued to be held in an unsecured location at the Denver office. Because the Department has responsibility under the program to report all deficiencies, it should have reported the problems to the County so that appropriate follow-up could be performed. Nonetheless, in its May 1999 report the Department did not cite Denver County for noncompliance in the section of the report requiring a corrective action plan regarding these deficiencies. Department staff stated that they did not cite the County, because local staff indicated that the

cards would be destroyed in the immediate future. The problem, however, continued. Department staff also reported that Denver County did conduct an inventory of the returned EBT cards in November 1999, which identified that 3,674 returned cards were on hand at that time. The Department visited Denver County again in August 2000; the report on that visit had not been issued at the time of our audit.

Also as part of our Fiscal Year 2000 audit, we visited the central Denver County Food Stamps office in September 2000 and found that despite assurances in May 1999 from County staff that the returned EBT cards would be destroyed, the cards were still sitting in an unsecured box. In other words, over two years after concerns were raised in the August 1998 performance audit, the Department had not ensured that the security issues raised by the handling of these returned EBT cards were addressed. When we brought these matters to the Department's attention again, Department staff contacted the County, and the County hired a vendor who destroyed the cards in late September 2000.

However, while the returned cards have finally been destroyed, the Department is unable to ensure that none of the cards were misappropriated and misused. Denver County staff did not take an inventory of the cards at the time they were destroyed. The County estimated that about 3,500 cards were destroyed; this is 174 cards fewer than the 3,674 cards inventoried in November 1999.

Finally, the August 1998 audit of EBT also recommended that the Department specify in its EBT procedures a time frame for the destruction of EBT cards returned for possible malfunction or damage. While the Department agreed with this recommendation and issued an agency letter to counties in November 1998 requiring daily destruction of returned cards, it inadvertently omitted the specific time frame for destruction from its revised EBT Procedures Manual issued in April 2000. The Department should correct the manual so that counties are clearly informed of the time frame in which returned cards must be destroyed.

- C The Department did not issue monitoring reports to counties within a consistent time frame.** In addition to failing to ensure that significant problems are corrected, the Department is not in all cases providing timely documentation of issues identified through on-site monitoring inspections. Further, they do not have documented goals for timely issuance of monitoring reports. For example, we found the Department did not complete and issue the monitoring report for the May 1999 Denver County review until December 1999, seven months after the review was completed. However, we found that the Department issued

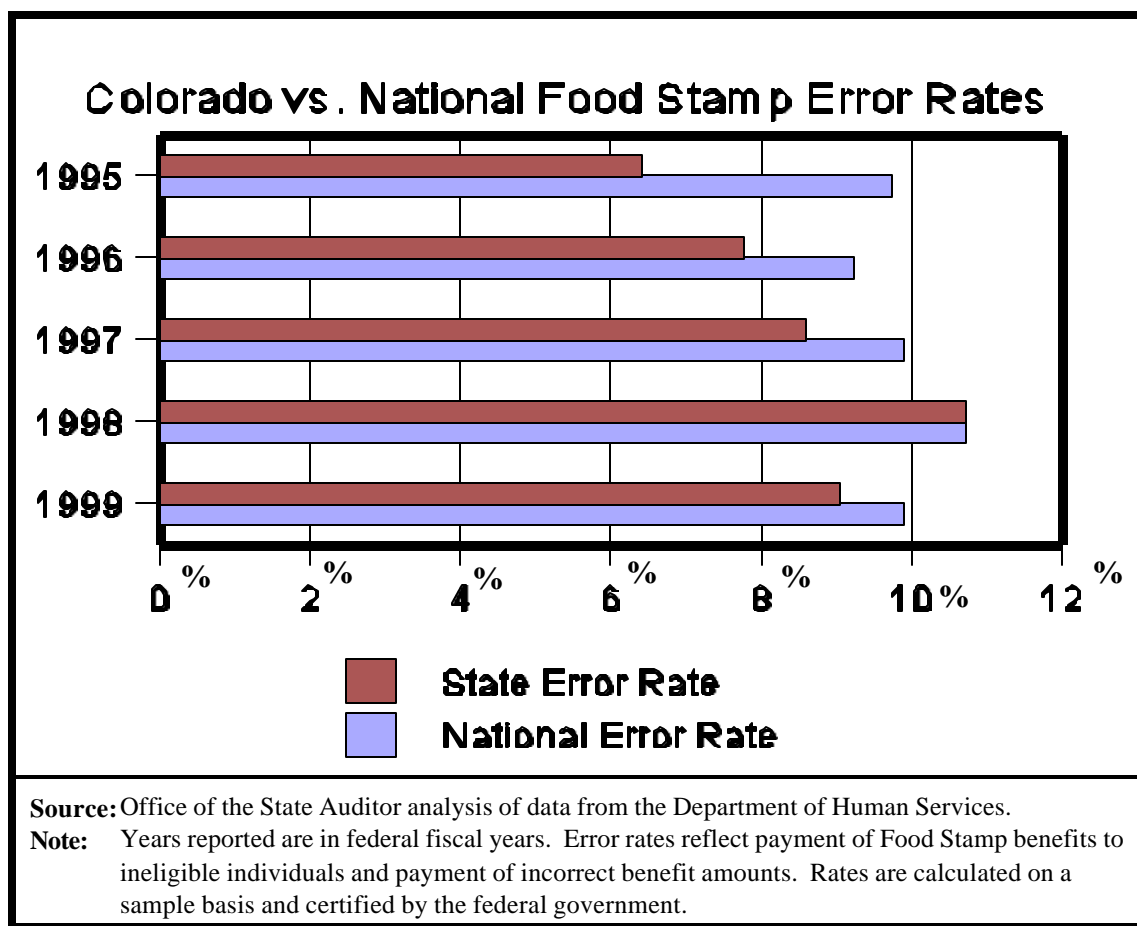
monitoring reports for Fiscal Year 2000 on-site visits to two other large counties and one medium county within about two months after the reviews were performed. While the Department provides verbal feedback at exit conferences with county staff, timely issuance of monitoring reports is especially important because Department management indicate that their receipt deadline for county corrective action plans is based on the date counties receive their monitoring reports. By establishing and striving to meet goals for timely issuance of reports and communicating these goals to counties, the Department can help ensure that counties are aware of and correct problems in a timely manner.

- C **The Department did not require Denver County to submit corrective action plans for all problems identified in the monitoring report within 30 days of receiving the report.** We found as of November 2000, Denver County had not submitted a corrective action plan for three issues identified in the Department's monitoring report issued to the County in December 1999. Thus, not only was there a seven-month delay between the Department's identification of problems in May 1999 and the report notifying Denver County in December 1999 of these problems, but almost a year after issuing the report the Department had no formal acknowledgment from Denver County as to how the County plans to address three of these problems. Department management indicated that counties are required to submit corrective action plans for all deficiencies within 30 days of receiving the monitoring report. They further indicated that Denver County did provide a corrective action plan for identified issues relating to the County's payment error rate. However, the Department has not sanctioned Denver County for not complying with the corrective action plan deadline for the other three issues.

States Can Be Sanctioned for High Food Stamp Error Rates

The purpose of the Department's oversight of county Food Stamp programs is to ensure that Food Stamp benefits are provided to appropriate individuals and that state and federal requirements are met. The Department's role is important because the federal government can issue financial sanctions against a state in which the payment error rate exceeds the average error rate across all states for the same period. Between federal Fiscal Year 1995 and 1999, Colorado's error rate has risen from about 6.4 percent to over 9 percent, an increase of over a third. As indicated in the chart below, since federal Fiscal Year 1995 the State's error rate has been closer to the average national error rate, and in federal Fiscal Year 1998 the State's error rate was the same as the national average. If the

State's error rate had been any higher in federal Fiscal Year 1998, Colorado would have received financial sanctions from the U.S. Department of Agriculture (USDA), which oversees the Food Stamp program. The State's error rate for federal Fiscal Year 2000 has not yet been certified by USDA.



Department Food Stamp management have indicated that the State's error rate has been significantly impacted by the Department's efforts toward implementing Colorado Works, the State's program for implementing federal Welfare Reform. The Department reports it established a payment accuracy team, conducted statewide training, and began providing quarterly payment error rate information to counties during Fiscal Year 1999 to identify and implement strategies for lowering the statewide error rate.

While we acknowledge these efforts, the problems identified during our audit indicate the need for the Department to strengthen its management evaluation review process to further ensure error rates are addressed. It is especially important for the Department to ensure

problems identified at Denver County are corrected because of the large impact the County has on the State's Food Stamp payment error rate.

Recommendation No. 58:

The Department should enforce state and federal requirements for the Food Stamp program as appropriate, including:

- a. Citing counties for all instances of noncompliance with Food Stamp policies and regulations in monitoring reports issued on county site visits.
- b. Following up in a timely manner on instances of noncompliance, and imposing sanctions as appropriate on counties that have ongoing problems and that do not make good faith efforts to improve.
- c. Documenting and adhering to goals for timely issuance of monitoring reports and communicating these goals to counties.
- d. Ensuring corrective action plans for all areas of noncompliance are received from counties within 30 days of the issuance of the monitoring report.

Department of Human Services Response:

- a. Agree. Program staff will continue to use both the Management Evaluation and error rate monitoring processes as vehicles for citation of performance problems and ensuring compliance.
- b. Agree. The Department will follow up on instances of noncompliance in a timely manner. The Department will develop standards for imposition of sanctions for counties that have ongoing problems that they do not make good faith efforts to address. Program staff are working to determine acceptable thresholds for sanctions regarding areas that are considered to be critical and not for administrative deficiencies. The sanction process already exists for an error rate in excess of the national average.
- c. Agree. The Program has established a goal of completing the monitoring report within 30 days of the review for small counties and within 60 days for large counties, and will communicate this goal to counties through the agency letter process.

- d. Agree. A compliance action plan will continue to be required for all critical areas of noncompliance within 30 days of issuance of the Management Evaluation monitoring report. The Program will continue to require counties to submit their Corrective Action Plans for the error rate within 30 days. The error rate for FFY 2000 is projected to be approximately 7.5 percent as the reduction strategies continue to improve the error rate.

Recommendation No. 59:

The Department of Human Services should update its EBT policies and procedures to specify a time frame for the destruction of Electronic Benefits Transfer cards that have been returned due to possible damage or malfunction.

Department of Human Services Response:

Agree. The Food Assistance Programs Division will update the EBT Administrative Training and Security Procedures Manual to reflect the daily destruction of lost/stolen/damaged EBT cards.

Ensure ADAD Subrecipients Are Monitored

In Fiscal Year 2000 the Department of Human Services expended approximately \$597 million in federal funding for more than 70 federal grants. The Department passes through much of this funding to other entities, or subrecipients, that administer the programs on the local level. The Department's main subrecipients are county governments; other subrecipients include public and nonprofit entities such as mental health centers, area agencies on aging, and alcohol and drug abuse managed service organizations. Under federal laws and regulations the Department, as the primary recipient, is responsible for ensuring that subrecipients meet federal program requirements. These requirements include using federal funds only for allowable expenditures, accurately determining who is eligible for benefits, and reporting program expenditures and performance.

The Field Audits Division at the Department is responsible for specific aspects of the Department of Human Services's (DHS) subrecipient monitoring activities to ensure federal compliance. As part of this, Field Audits performs on-site monitoring visits and reviews subrecipients' annual independent audit reports. These audits are conducted in

accordance with the federal Single Audit Act, which requires that auditors assess an entity's compliance with federal requirements if the entity expends \$300,000 or more in federal funds during the year. Field Audits reviews the reports to identify questioned costs or other compliance issues specified by the independent auditors. Field Audits is responsible for working with subrecipients to ensure they develop and implement corrective action plans to address any deficiencies noted in these audit reports.

We found that the Department adequately ensures that audit reports from counties and mental health centers are received, reviewed, and followed up on as needed. In Fiscal Year 2000, counties alone accounted for approximately \$418 million, or 70 percent, of the total federal funds passed through to subrecipients by DHS. However, we found that in Fiscal Year 2000 the Department did not review annual independent audit reports for three of four Managed Service Organizations (MSOs). These MSOs contract with the Department's Alcohol and Drug Abuse Division (ADAD) to provide treatment under the federal Block Grants for Prevention and Treatment of Substance Abuse program (CFDA #93.959). These three MSOs received approximately \$21.3 million of federal block grant funds in Federal Fiscal Year 2000, or about 94 percent of the total funds expended by ADAD during that time. These three MSOs contracted with 37 drug and alcohol abuse treatment service providers during that time to provide services to about 199,000 individuals.

We noted in our Fiscal Year 1996 and 1998 audits that the Department did not review audit reports submitted by all ADAD subrecipients. If audit reports are not reviewed, the Department lacks information about possible compliance problems at the subrecipient level that need to be addressed. The Department should ensure that it meets requirements to review the ADAD subrecipient audit reports every year.

Recommendation No. 60:

The Department of Human Services should perform reviews of annual independent audit reports for all subrecipients as required under the federal Single Audit Act and follow up on problems identified as necessary.

Department of Human Services Response:

Agree. We plan to complete the desk reviews of the three MSOs' by December 31, 2000. We will prioritize workload schedules to ensure the desk reviews are done in the future. We are also working with ADAD to enhance monitoring efforts through on-site reviews of MSOs' and are assisting with developing

industry audit guidelines for MSOs to be published by the Department in the Mental Health Audit and Accounting Manual.

Strengthen Case Management and County Monitoring Related to the Child Support Enforcement Program

In Fiscal Year 2000 our office performed follow-up on recommendations included in a June 1999 Office of the State Auditor performance audit of the State's Child Support Enforcement Program (CFDA #93.563). When we performed our follow-up, we continued to note concerns with the administration of the program. The purpose of CSE is to collect child support obligations owed by absent parents, locate absent parents, and establish paternity. During Fiscal Year 2000 the Department of Human Services expended about \$53.2 million in state and federal funds for the operation of the program.

Summarized below are recommendations 3 and 4 from the June 1999 report, the Division's original responses, the Division's discussion of actions it has taken to address the recommendations, our evaluation of those actions, and a discussion of the tasks that are still outstanding. For more information on the June 1999 performance audit, see *Child Support Enforcement, Department of Human Services*, Report No. 1122.

Improve Case Management

During the 1999 audit we reviewed a statistically valid sample of 407 child support cases. We found problems in 80 (20 percent) of the cases, ranging from inaccurate data entry to lack of required enforcement efforts. Some problems resulted in incorrect enforcement actions, including collection of the wrong amounts from non-custodial parents. In other cases, enforcement actions were not carried out properly and the need to correct problems diverted staff from other important duties.

Recommendation No. 61:

The Division of Child Support Enforcement should ensure appropriate actions are taken on child support cases by:

- a. Reviewing existing caseloads to identify cases that have gone for long periods of time with no activity to determine appropriate disposition.
- b. Developing an agency letter on the use of monitoring tools, such as calendar reviews.
- c. Providing additional training on caseload management, including calendar reviews.

Division of Child Support Enforcement Response (June 1999):

- a. Agree. During the time period of August 1999 through July 2000, the Division will request that counties review their cases to determine if any can be closed using the revised federal case closure criteria and to ensure that all cases are in the proper category on the Automated Child Support Enforcement System (ACSES). The Division agrees that all child support cases must be given the attention needed to maximize the chances of collecting child support.
- b. Agree. By December 31, 1999, the Division will produce an agency letter providing counties instruction on the use of monitoring tools including calendar reviews.
- c. Agree. The ACSES provides all information to support caseload management. During the time period of August 1999 through July 2000, the division will train counties on the efficient use of these mechanisms:
 - C Management reports
 - C Calendar review messages
 - C Locate response information

Implementation Date: July 2000.

Division of Child Support Enforcement Update (May 2000):

In progress.

The Division:

- Conducted statewide training to instruct counties on reviewing their caseloads to ensure that all cases are in the proper case category and to take the next appropriate action on all cases that have gone for long periods of time without activity.
- Will draft and disseminate an agency letter advising counties of all monitoring tools available and how to use the tools.
- Trained counties on how to use ACSES reports to manage caseloads; how to effectively use locate response information; how to use ACSES triggers to prioritize daily workload; what effect good caseload management will have on performance measures; content of OCSE-157 and how staff performance is reflected and reported nationwide.
- Researched whether resources are available to provide additional on-line and new worker training classes to county staff. The Division concluded that resources were not available.

Office of the State Auditor's Evaluation of Actions Taken (May 2000):

The Division developed a report that identifies cases that have gone for 90 consecutive days with no activity. The counties have been instructed to review the cases identified in this report to determine their appropriate disposition. According to the Division, it plans to develop and distribute this report to counties on a quarterly basis. The Division also conducted training for the counties on overall caseload management, including caseload review and monitoring tools, such as calendar reviews. At the time of our review, however, the Division had not yet completed the agency letter advising counties of all monitoring tools available and how to use the tools. The Division still needs to complete the agency letter on monitoring tools and monitor cases identified in the report described above to ensure that counties have reviewed the cases and taken the appropriate action.

Division of Child Support Enforcement Update (December 2000):

The Division completed the agency letter advising counties of all monitoring tools available and how to use the tools. The Division forwarded Agency Letter (CSE-00-9-P) along with a complete Procedure (#CSE 2.5) to counties on August 29, 2000.

Ensure Counties Comply With Regulations

In our 1999 audit we found numerous instances of counties not complying with state and federal child support regulations. These problems included 8 cases in which the data in the State's automated system were not accurate and 70 cases in which counties did not meet the federal time requirements for specific child support enforcement actions. Data need to be accurate for the appropriate actions to be taken. Timeliness of actions taken is also important. For example, opening a case by establishing a case record and entering relevant information into the automated system is the first step in the child support process. If this action is not completed in a timely manner, the remainder of the process will be unduly delayed. The Division has recognized that some counties struggle to comply with the state and federal requirements.

Recommendation No. 62:

The Division of Child Support Enforcement should continue to work with the counties that are not in compliance with state child support regulations, including those on documenting cases. It should impose sanctions on those counties that have ongoing problems with compliance and that do not make good faith efforts to improve.

Division of Child Support Enforcement Response (June 1999):

Agree. The Division is committed to improving compliance rates and will continue to work with counties to improve compliance and performance, including documentation of cases. Recent federal regulations require that states conduct their own child support program self-assessment. The Division embraced these new regulations and developed a comprehensive IV-D evaluation process to:

assess county compliance and performance; take corrective action to improve appropriate areas; and to monitor ongoing county compliance and performance levels. As a part of this county assessment, the Division will impose penalties as necessary pursuant to Staff Manual Volume 6, Section 6.140, for counties who do not make good faith efforts to improve their compliance with federal and state statutes, rules and regulations.

Implementation Date: July 1999.

Division of Child Support Enforcement Update (May 2000):

Implemented.

The Division has continued to refine the selection process for Root Cause Analysis to focus on counties where the state can achieve significant gains in performance.

Office of the State Auditor's Evaluation of Actions Taken (May 2000):

This recommendation has not been implemented. While the Division has attempted to further refine the selection process for Root Cause Analysis (a tool for evaluating county performance), the Division has not demonstrated continued ongoing efforts to work with counties to achieve compliance with state child support regulations.

Division of Child Support Enforcement Update (December 2000):

The Division completed a thorough analysis and review of the tools used to monitor county performance. Included in the analysis was a review of the selection process for Root Cause Analysis (a tool for evaluating county performance). Upon the recommendation of the Evaluation Subcommittee and with the approval of the IV-D Task Force, the Division refined the Root Cause Analysis process to look at performance areas rather than geographic areas. This change will be implemented effective January 1, 2001.

Mental Health Services

The State has a unified mental health system under which eight Mental Health Assessment and Service Agencies (MHASAs) provide mental health services to all Medicaid eligibles within the MHASA's geographic service area. Please refer to page 69 in the Financial Statement Findings section for additional background information.

The following comment was addressed in the *May 2000 People With Developmental Disabilities Performance Audit* report.

Eliminate Duplicate Funding Streams and Clarify Funding Streams for MHASAs and the Regional Centers

The Medicaid program makes capitated payments to MHASAs on behalf of all Medicaid eligibles each month. Capitated payments for people with developmental disabilities range between \$26 and \$75 per person per month, depending on the area of the State. These payments are significant. In addition to these capitated payments, four CCBs, three Regional Centers, and the Developmental Disabilities Services Section (DDS) spent funds on services provided by mental health professionals outside of the capitated mental health system for the people in our sample area.

CCBs are purchasing services outside of the mental health system because they are unable to get adequate service from MHASAs. Further, the three Regional Centers provide their own mental health services for about 400 people, each of whom is eligible for mental health services through the mental health system. The Department must address duplicate funding streams for the mental health system and the Regional Centers. Please refer to Recommendation No. 16 in the Financial Statement Findings section for additional details, our recommendation, and the Department's response.

Department of Public Health and Environment

Introduction

The Department of Public Health and Environment is authorized by Section 24-1-119(1), C.R.S. The Department is responsible for monitoring environmental quality, assuring the quality of health services, and maintaining health data for the State. The mission statement states that the Department is "committed to protecting and preserving the health and environment of the people of Colorado." The 11 major divisions are as follows:

- Health Facilities
- Emergency Medical Services and Prevention
- Diseases Control and Environmental Epidemiology
- Family and Community Health Services
- Health Statistics and Vital Records
- Air Pollution Control
- Water Quality Control
- Hazardous Materials and Waste Management
- Consumer Protection
- Laboratory and Radiation Services
- Administrative Services

For Fiscal Year 2000 the Department had an operating budget totaling in excess of \$226 million. This budget supports 1,064.2 full-time equivalent staff (FTE).

The public accounting firm of Clifton Gunderson LLC, performed the audit work of the Nursing Facility Quality of Care. The following comments were addressed in the *September 2000 Nursing Facility Quality of Care Performance Audit* report.

Oversight of Nursing Facility Quality of Care

To promote quality of care at nursing facilities, the General Assembly established the Quality Care Incentive Payment program (QCIP) in 1994. The purpose of the QCIP

program is to provide financial incentives to nursing facilities for delivering high-quality care. The State paid about \$4.4 million in state and federal Medicaid funds to nursing facilities for QCIP incentive payments during Fiscal Year 2000. Of this amount, \$1.3 million was allocated to nursing facilities based on a single quality of care measure—deficiencies identified through federally mandated certification surveys and complaint investigations conducted by the Health Care Facilities Division (Division) at the Department of Public Health and Environment.

Quality of Care Monitoring Activities

One of the primary ways the Division oversees quality of care at nursing facilities is through investigations, termed “surveys,” mandated by the federal Health Care Financing Administration (HCFA). All 224 Colorado nursing facilities that participate in either the federal Medicaid or Medicare programs receive unannounced surveys by the Division at least once every 15 months. Interdisciplinary survey teams, primarily composed of registered nurses, dietitians, therapists, and social workers, assess whether the quality of care provided at the facility complies with federal regulations.

In addition to conducting surveys, the Division investigates complaints and occurrences. Complaints may be alleged by anyone, but occurrences are incidents, such as patient abuse or serious injury, that are self-reported by the nursing facility. All investigations, whether resulting from surveys, complaints, or occurrences, may identify deficient practices that can adversely impact quality of care. Deficient practices are categorized by 196 deficiency “tag” numbers, and coded for scope and severity. Scope and severity codes determine the actions nursing facilities must take to remedy a deficiency and also establish the sanction that will be imposed. Scope and severity codes are displayed in the following chart:

Scope and Severity Codes for Medicare and Medicaid Compliance Deficiencies			
Severity of Deficiency	Scope		
	Isolated	Pattern	Widespread
Actual or Potential for Death or Serious Injury	J	K	L
Other Actual Harm	G	H	I
Potential for More Than Minimal Harm	D	E	F
Potential for Minimal Harm (Substantial Compliance)	A	B	C
Source: Federal Health Care Financing Administration.			

Facilities with A, B, or C deficiencies are in substantial compliance and no remedy or sanction is assigned. Deficiencies coded D through L become progressively more serious and subject facilities to remedial actions and sanctions.

Federal regulations require the Division to follow up promptly on all deficiencies cited that are coded B or greater. Follow-up entails either an on-site or paper review. The nursing facility must submit a plan of correction, and the Division must resurvey the facility within 90 days or the facility will be denied payments for new Medicare and Medicaid patient admissions. If the deficiency has not been corrected, the deficiency is cited again and more stringent sanctions may be imposed. Deficiencies, scope and severity codes, sanctions, and resurvey results are all reported to the public on the Division's Web site.

Quality of Care Issues at Nursing Facilities

As we have discussed, deficiencies cited through certification surveys and complaint investigations are the primary way the Division measures and assesses quality of care at nursing facilities. Additionally, these investigations form the basis for \$1.3 million in incentive payments for QCIP, the State's financial incentive program for nursing facilities. We reviewed the Division's oversight of nursing facility quality as monitored through

certification surveys and complaint and occurrence investigations. Our audit included review of data from several sources:

- We compared survey deficiencies identified by Division surveyors with deficiencies identified by HCFA surveyors.
- We used the expertise of nurse consultants to observe the effectiveness of Division surveyors in identifying quality of care issues during surveys.
- We compared survey deficiencies in Colorado with regional and national data.

We found that, in general, the Division is conducting surveys and complaint investigations in accordance with the protocols set forth by HCFA. Additionally, the Division makes detailed information on the results of these investigations available to the public through its Web site. We commend the Division for the value of the public information maintained on its Web site.

We also noted quality of care concerns at nursing facilities. The Division needs to improve its surveys to better identify quality issues at nursing facilities, as discussed below.

Deficiencies Cited by HCFA Surveyors

HCFA provides oversight of the Division's survey process by conducting comparative surveys (where HCFA resurveys the nursing facility within 60 days of the Division's survey). We reviewed these surveys as one indicator of the Division's effectiveness in identifying quality of care issues. HCFA conducted four comparative surveys in Colorado between February of 1999 and March of 2000. These surveys were conducted between 12 and 32 days after the Division's surveys, depending on the nursing facility. We found that HCFA surveyors cited eight times the deficiencies that Division surveyors did. In contrast, HCFA cited about two times the deficiencies as surveyors in other Region VIII states (HCFA Region VIII states include Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming). For three Colorado facilities with a total of 49 deficiencies, HCFA determined that 28 deficiencies would have been present when Division surveyors were on-site. Further, of 73 deficiencies identified by HCFA surveyors, 15 related directly to quality of care standards, including pressure sores, nutrition, and hazards for residents. These comparative surveys raise questions about the effectiveness of the Division's surveys in uncovering quality of care concerns at Colorado nursing facilities.

On-Site Reviews

We contracted with three registered nurse consultants to conduct on-site evaluations of two surveys conducted by Division surveyors and to review 25 completed survey files. Our consultants, with 30 cumulative years of experience reviewing quality of care issues, made the following observations:

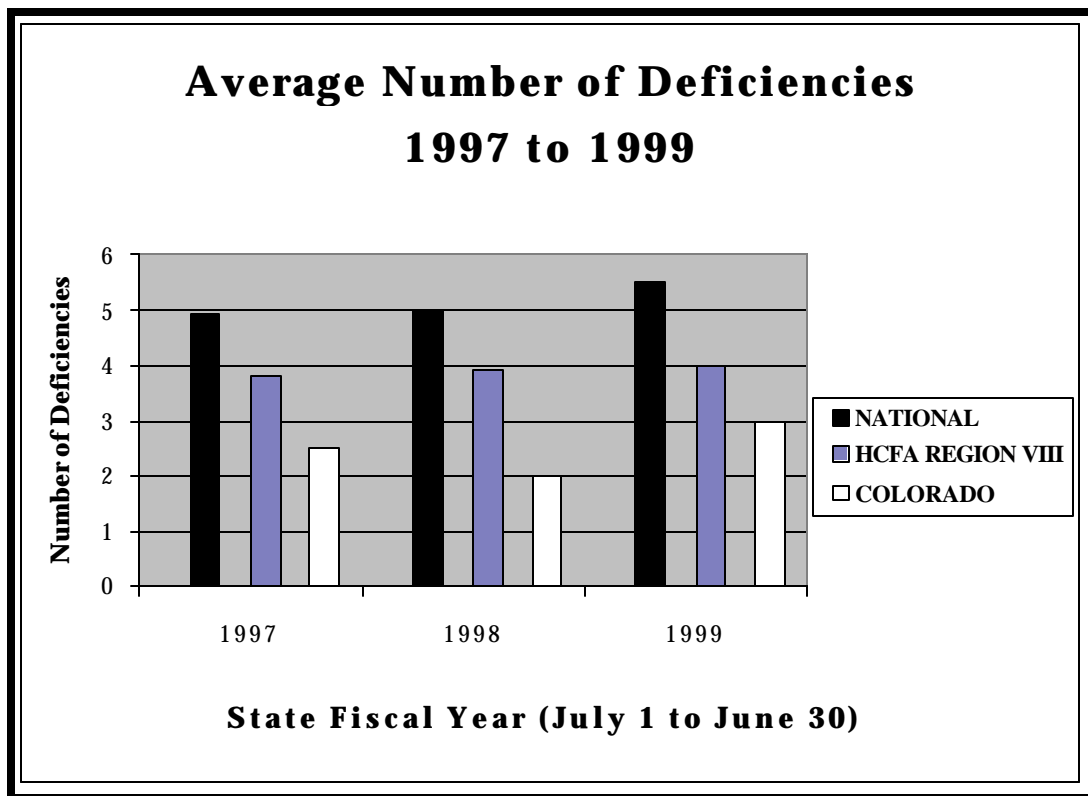
- **Division surveyors did not identify a significant medical treatment issue for investigation at one nursing facility.** Our review determined that there was a quality of care issue related to the nursing facility's treatment of pressure sores. Pressure sores were observed on more than one resident. In one instance, the pressure sores developed during the resident's stay at the facility and progressed to wet gangrene. The resident had to have his foot amputated. Division surveyors did not investigate pressure sores during the survey until our nurse consultants brought these concerns to the survey team's attention. A deficiency was subsequently cited. At another facility, we observed that Division surveyors did not follow HCFA investigative protocols for three pressure sores identified on a resident.
- **Division surveyors did not appropriately assign scope and severity to a housekeeping and maintenance deficiency at one facility.** Division surveyors noted numerous problems with dirt and grime throughout the facility. The surveyors assigned a scope and severity of "E" (a "pattern" of incidents with potential for more than minimal harm). Our nurse consultants would have assigned a scope and severity of "F" ("widespread" problem with potential for more than minimal harm) because the problem was evident in 48 of 75 rooms, 3 of 4 dining rooms, and 5 of 5 units at this facility. An "F" sanction is significantly more serious than an "E" sanction, since more severe penalties may be imposed.
- **Division surveyors overlooked problems with administering pain medication at one facility.** During the survey at one facility, our nurse consultants observed a resident who was exposed and in substantial pain. The resident had a doctor's order for pain medication each hour as needed, but the resident had not received his pain medication for at least five hours. The Division's surveyor noted that the resident was exposed, but did not observe that the resident was in pain and had not received his pain medication. Although the Division cited a dignity deficiency, no focused review or investigation of pain control occurred during the survey. Additional focused review may have resulted in citing a deficiency.

- **Division surveyors did not thoroughly investigate infection control issues at one nursing facility.** During the initial tour of the facility Division surveyors noted catheters hanging in one resident room with the tips exposed and lying on the floor. The exposed catheters should have raised an issue about the facility's commitment to infection control; however, Division surveyors did not investigate this issue further. The Division cited infection control as an "A," indicating substantial compliance. The Division could have substantiated a scope and severity of "D" if surveyors had conducted the investigation as warranted by the circumstances.
- **Division surveyors did not consistently comply with HCFA documentation requirements.** Our survey observations noted that Division surveyors filed incomplete forms, did not record the number of required resident interviews on sampling forms as required by HCFA, and modified the sample size without documenting the rationale. During our review of 25 completed survey files, we noted that 14 of 25 files contained incomplete forms required by HCFA and 5 of 25 files contained at least one missing document. Of 25 files, 11 Resident Review Worksheets were not completed as required by HCFA regulations. Resident reviews are critical because they often uncover problems with quality of care. Complete documents are important for supervisory review, to substantiate deficiencies, and to withstand scrutiny upon appeal.

Our review of HCFA comparative reports revealed that HCFA surveyors identified some of these same issues during their surveys at different nursing facilities. For instance, HCFA also raised issues concerning pressure sores in prior surveys. In each instance, HCFA surveyors cited deficiencies when Division surveyors did not.

Deficiencies Cited in Colorado and Other States Regionally and Nationally

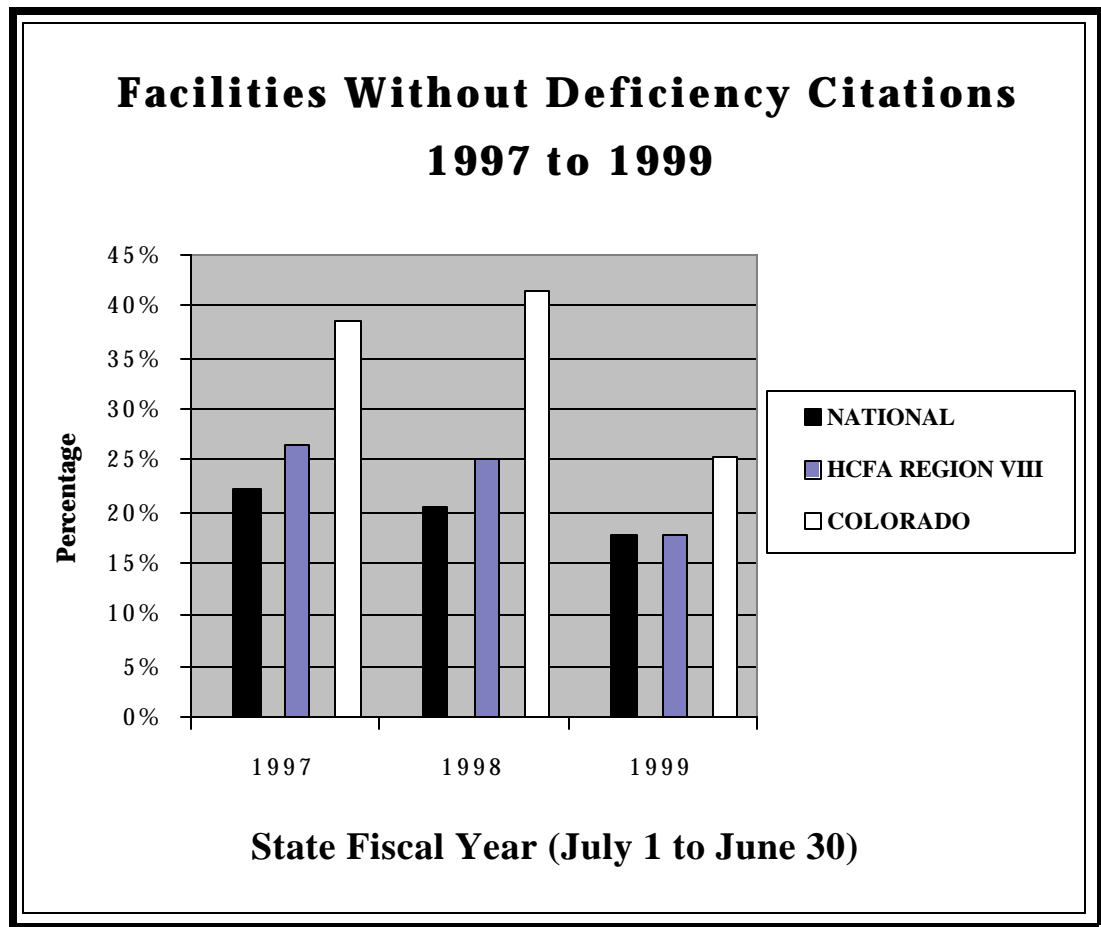
We compared deficiencies cited during surveys in Colorado with federal data available at national and regional levels (HCFA Region VIII states include Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming). We found that during the past three years the Division's surveyors have identified, on average, 51 and 36 percent fewer deficiencies, respectively, than other states nationally and regionally. Deficiencies cited for the past three years are shown in the following graph.



Source: American Health Care Association's *Nursing Facilities' Deficiency Report*.

From these data one could conclude that Colorado's nursing facilities are providing higher-quality care than other states nationally or in Region VIII. However, when this information is viewed along with the data already presented in this report, this raises questions about Colorado's oversight of quality of care through surveys.

We also found that, on average, 35 percent of Colorado facilities were not cited with any deficiencies during the past three years. In contrast, an average of 23 and 20 percent of facilities, respectively, in Region VIII and nationally were not cited with any deficiencies. These data are presented in the following graph.



Source: American Health Care Association's *Nursing Facilities' Deficiency Report*.

Further, we found that Colorado cites deficiencies with an average lower severity than other states nationally and regionally. For example, substantially fewer facilities in Colorado receive deficiencies coded with a scope and severity of "F" or higher. A facility cited with a deficiency of "F" or higher will be subject to more serious sanctions, including monetary penalties, than a facility cited with deficiencies coded at D or E. The percentage of deficiencies coded at "F" or higher in Colorado, Region VIII, and nationally is displayed in the following chart.

Comparison of Scope and Severity Ratings Colorado, Region VIII, and U.S. Federal Fiscal Year 1999			
Scope and Severity	Colorado	Region VIII	United States
A through E	93%	83%	82%
F through L	7%	17%	18%
Source: American Health Care Association's <i>Nursing Facilities' Deficiency Report</i> .			

The chart shows that, during 1999, about 7 percent of the deficiencies cited in Colorado had a scope and severity of F or greater and 93 percent had a scope and severity of E or less. In contrast, about 18 percent of the deficiencies cited nationally during 1999 had a scope and severity of F or greater and about 82 percent had a scope and severity of E or less.

These graphs and charts show that Colorado is an outlier in terms of both the number and scope and severity of deficiencies cited. Again, these data raise questions about whether the Divisions' surveyors are effectively uncovering quality of care issues at Colorado nursing facilities.

Increased Training and Supervision Are Needed

The importance of citing a deficiency, when supported by adequate evidence, cannot be overstated. Federal rules require that all deficiencies of B or greater result in a plan of correction. The plan of correction must be submitted by the nursing facility within 10 calendar days. Additionally, federal rules require the Division to resurvey any facility with a deficiency of G or greater. The facility must be in substantial compliance within 90 days or the facility will be denied payment for new Medicaid and Medicare patient admissions. The resurvey is focused on reviewing the issues that led to citing the deficiency. If the deficiency is cited again, sanctions may be imposed by the federal government.

The Division resurveys all facilities with a deficiency of B or greater within 90 days. For a sample of 19 nursing facilities with deficiencies cited at B or greater, we found that all 19 facilities submitted required plans of correction within specified time frames. Resurveys also occurred within 90 days as required by federal rules. In each instance, the deficiencies were corrected and no further deficiencies were cited.

Since deficiency citing is key to ensuring nursing facilities correct quality of care issues, it is critical that Division surveyors identify and thoroughly investigate potential deficiencies and cite and code them appropriately. The Division can improve its deficiency citing as explained below.

First, we identified a need for increased teambuilding for Division surveyors. HCFA requires a multidisciplinary composition for all survey teams nationwide. Survey teams must include professionals from multiple disciplines, such as dietitians, therapists, and social workers, in addition to nurses. The Division's survey teams are composed of the mix of professionals required by the federal government. However, multidisciplinary teams need strong teambuilding skills to operate effectively. Through increased training and teambuilding, the Division can ensure that all survey team members have an awareness of clinical issues and can appropriately identify quality of care concerns.

Second, we noted a need for increased training. The Division reports problems with staff turnover. As the Division hires new staff to replace those who leave, fewer staff have experience conducting surveys. Our review of staff experience confirms this fact. Of 23 nursing facility surveyors who spend most of their time on-site at facilities, over half have three years or less experience, and 26 percent have one year or less experience. Division staff report that these newer staff have not had the same training opportunities as more experienced staff. For example, the Division developed a training program on investigative protocols that it presented to its own surveyors and to other states nationally. It reports that three of its nursing facility surveyors have not yet had this training. The Division is currently revising this training and will provide the training to these surveyors when revisions are complete.

Third, Division staff report that more structured observations by supervisors while teams are on-site are needed. According to the Division, for 227 surveys conducted during Fiscal Year 2000, about 12 had structured observations by supervisors. The Division plans to use HCFA surveys, quality indicators, and informal reviews of completed surveys to identify issues that need to be observed and reviewed while teams are on-site. Additionally, the Division plans to increase the number of on-site survey observations completed by supervisors.

Recommendation No. 63:

We recommend the Health Facilities Division increase focus on quality of care and deficiency citing through certification surveys. This should include:

- a. Training to enhance cross-disciplinary understanding, focusing on investigative protocols, scope and severity ratings, deficiency tag assignments, and resident risks observable through interviews, patient records, facility records, and facility inspections.
- b. Structured on-site review by supervisors of survey team activities.
- c. Teambuilding techniques to ensure timely communication occurs throughout the survey process.

Health Facilities Division Response:

Agree. The Division is committed to improving its focus on quality of care and deficiency citing and will increase surveyor training, on-site supervision, and teambuilding. The Division has hired a Clinical Nurse Field Manager to provide additional on-site supervision of survey teams and is scheduling a gerontological nursing assessment training for all surveyors and supervisors.

Although we agree with the auditors' recommendation, we disagree with the report text in the following areas. First, we disagree with the assumption that HCFA comparative survey results are comparable to the surveys done by the Division. HCFA comparative surveys are completed at different times and with more resources than those available for state agency use. Other states have raised concerns about HCFA comparative surveys and HCFA indicates it will be implementing a state appeals process in the future. Second, we disagree with the consultants' on-site observations. Our disagreement is based on differences in how we perceive the facts and on differences in professional opinion. For example, our survey team identified pressure sores as a potential problem prior to entering the facility, rather than in response to the consultants' comments. Finally, we disagree with the assumption that a simple comparison of the number of deficiencies in Colorado and other states is valid. This comparison does not recognize that legitimate factors such as Medicaid reimbursement rates, state licensure laws and regulations, consumer information, and the involvement of the state's ombudsman program may cause variances from state to state.

These disagreements, however, do not diminish the Division's agreement with the recommendation.

Conflict of Interest Statements

The federal government requires all Division surveyors to complete a conflict of interest statement to maintain the integrity of surveys and investigations. The purpose of the conflict of interest statement is to identify any relationships between Division employees and a nursing facility that would impact the objectivity or credibility of a survey or investigation. We reviewed the Division's conflict of interest statements and identified the following problems:

- **Some conflict of interest statements were missing or outdated.** Of a sample of 10 employees, the Division could not find conflict of interest statements for 2 people. Additionally, conflict of interest statements for two employees had not been updated since 1995. If conflict of interest statements are missing or out of date, the Division may not be aware of relationships between surveyors and nursing facilities that could jeopardize the outcome of a survey or investigation.
- **The supervisor who staffs and schedules surveys does not maintain a list of potential staff conflicts of interest.** As a result, the supervisor could inadvertently assign staff to a survey or investigation who may have a business or personal relationship with nursing facility staff. This could compromise the outcome of the investigation at that nursing facility.
- **Conflict of interest statements do not require employees to certify that they have not accepted payments or gifts from nursing facilities or related parties.** Again, this information is important for ensuring that Division staff observe ethical behavior and maintain the objectivity and credibility of the Division's oversight of nursing facilities.

Recommendation No. 64:

The Health Facilities Division should improve its oversight of employee conflicts of interest by requiring all staff to complete and update their conflict of interest statements annually. Division supervisors should review these statements and consider conflicts of interest before assigning staff to surveys or investigations. The Division should modify its conflict of interest statements to require each employee to certify that he or she has not accepted payments or gifts from any nursing facilities or their related parties.

Health Facilities Division Response:

Agree. The Division has asked its employees to complete a current conflict of interest form and has distributed information reminding employees of its conflict of interest policies. The forms will be updated at least annually and as necessary when changes occur. In addition, employee conflict of interest information will be incorporated in the Division's data system where it will be accessible to supervisors.

Department of Public Safety

Division of Criminal Justice

The Department of Public Safety is responsible for providing a safe environment for the citizens of Colorado. Within the Department, the Division of Criminal Justice is responsible for improving the administration of the criminal justice system in Colorado. Please refer to page 93 in the Financial Statement Findings section for additional background information.

Salaries Charged to Federal Grants Should Be Properly Supported

Many staff within the Division spend their time working on several federal programs. We found that the Division does not maintain actual time records that would allow it to accurately allocate time spent on each federal program. Please refer to Recommendation No. 27 in the Financial Statement Findings section for additional details, our recommendation, and the Division's response.

Byrne Formula Grant Program

The Byrne Formula Grant, administered by the Division, is one of the largest sources of non-operating law enforcement monies for systems and program improvements throughout the State. Federal law lists 26 different purposes that Byrne Formula Grant monies may be used for, such as a variety of anti-drug efforts including multi-jurisdictional task force programs, career criminal prosecution programs, and programs to improve the criminal and juvenile justice system's response to domestic and family violence. At least 5 percent is required to fund criminal history improvement projects. Priority is given to multijurisdictional task forces and criminal history improvement projects. An average of about \$7.4 million is awarded annually to the Division.

Maintain Compliance With the Cash Management Improvement Act

The Cash Management Improvement Act (CMIA) regulates the transfer of funds between federal and state agencies for federal grants. This is implemented through an agreement between the U. S. and State Treasury (Agreement). The Agreement requires that the Division request funding so that payment vouchers are reimbursed by federal funds five days after issue. Indirect costs of administering the grants are required to be recovered proportionally with each drawdown request. The Division's Byrne Formula Grant Program and Violent Offender Program, which provides funds to expand and build facilities for violent offenders, is subject to the Agreement. During our Fiscal Year 2000 audit we found that the Division is not in compliance with the Agreement.

We discovered that the Division is drawing down funds about once a month. The amount drawn is based on expenditures incurred and expected expenditures through the end of the month. For the Byrne Program, our testing of the drawdown in the months of March and May predominantly showed that the State lost interest by not drawing funds soon enough, but also noted instances in which funds were drawn before the expenditures were incurred. For the months tested the State lost approximately \$6,000 in interest. For the Violent Offender Program the only drawdown was done in June for reimbursement of expenditures occurring throughout the entire fiscal year.

Our audit showed that reimbursements for indirect costs are not being requested appropriately. Indirect costs are those costs that cannot be directly related to the administration of a specific program. For example, the expenses of operating the Executive Director's Office benefit the Division as a whole, but do not usually relate to a specific federal program. However, a percentage of these indirect costs may be requested and paid for through federal programs. The indirect costs must be requested proportionally in each drawdown. For the Byrne program, instead of drawing down a portion of the indirect costs in each request, the Division claimed a total of \$29,087 on two separate occasions. The Violent Offender Program had \$1,000 in indirect costs charged on one request. Although this only resulted in less than \$10 in interest costs to the State, this method of indirect cost reimbursement does not meet regulatory requirements.

Cash management procedures ensure that drawdowns are made according to the Agreement and indirect costs are properly included in the requests. The Division may be incurring a federal interest liability or cause a loss of interest earnings to the State by failing to comply with the Agreement.

Recommendation No. 65:

The Division of Criminal Justice should ensure compliance with the Cash Management Improvement Act by:

- a. Making draws in accordance with the Agreement.
- b. Including indirect costs proportionately in each drawdown.

Division of Criminal Justice Response:

Agree. The Division will work with the State Treasurer's Office to develop an implementation plan for procedures which will bring them into compliance with the Cash Management Improvement Act and the U. S. Treasury - State Agreement. The estimated implementation date is December 31, 2001.

Evaluate Site Visit Plan for Subgrantees

The Division is required to subgrant 60 percent of the Byrne Formula Grant Program to local entities. On top of this, subgrants are also made to other state agencies. There are between 70 and 90 subgrantees each year, sharing in the 1999 award of \$7.5 million. The average award under the 1999 grant was \$148,464. *OMB Circular A-133* requires that the State monitor subgrantees to ensure that federal funds are being spent according to their mandated purposes. This requirement is met through a review of subgrantee's Single Audit Reports. Although compliance with *OMB Circular A-133* has been achieved, the Division was unable to follow its internal policy regarding site visits due to staffing issues.

The internal policy states that site visits will be conducted when specific issues are noted, will be chosen based on the level of funding granted, and will be selected based on various other criteria. In addition, it stated in its Strategic Plan, which is part of the application package for the grant, that it will conduct site visits to enable staff to describe the project comprehensively, discuss the impact of the project on the community, and provide technical assistance to subgrantees. The Division performed site visits during the last two weeks of the fiscal year.

Six subgrantees were visited. At this rate it would take about 15 years to visit each subgrantee. The typical time period for the grants is four years. With such coverage many subgrantees would not receive any site visits, which is not consistent with the Division's internal policies. We found that only two of the six visits were for dollar amounts exceeding the average grant award.

The Division should develop a schedule of site visits that will allow it to meet its internal policies. Currently the extent of site visits performed violates departmental policy and conflicts with the Strategic Plan submitted to the federal government.

Recommendation No. 66:

The Division of Criminal Justice should develop a schedule to satisfy the objectives stated in the Strategic Plan as well as in its internal policies.

Division of Criminal Justice Response:

Agree. The Division has developed an accelerated schedule in order to complete the site visits that were not conducted as a result of the loss of three grant managers, including the manager of the unit, within a four-month period during Fiscal Year 1998 - 1999. Replacement personnel are in place and grant monitoring training has been completed. The aggressive schedule already is on track to bring the unit into full compliance with the Division's policy within one year. This was implemented in July 2000.

Accurately Compile Financial Status Reports

An SF-269 Financial Status Report must be filed with the federal Bureau of Justice Assistance every quarter. The report contains federal expenditures, state and/or matched expenditures, and remaining balances for the individual grant programs. During our Fiscal Year 2000 audit we noted the following problems in the preparation of this report for the Byrne Formula Grant Program:

- **Program income is not reported accurately.** Program income is earned in a variety of ways including through the sale of seized property by subgrantees. The expenditure of the program income is reported to the State and by the State to the federal government when the assets have been liquidated into cash. The income

must be spent for program purposes, but commonly is not expended until the subsequent year pending the decision of the subgrantee's local board on exactly how to allocate the income. If the income was earned under the 1999 grant, the related expenditures must be reported against the 1999 grant, even though they may not have occurred in Fiscal Year 2000. We found that subgrantees reporting expenditures of program income in the year in which they occurred, not against the grant that the income was earned under. As a result, the Division is manually allocating portions of program expenditures amongst grant years. In one instance, because program expenditures were reported incorrectly, reports showed that they spent more program income than they earned for their 1999 grant by \$13,362. We found five out of nine instances where the Division had to allocate income between grant years because the subgrantee reported the program expenditures incorrectly.

- **Administrative expenditures for the match portion of the grant are not reported in a timely manner on the Financial Status Report.** Although the Financial Status Report is based on the grant system and reconciled monthly to the State's accounting system, the administrative expenditures for the cash match portion of the grant are not always updated on internal grant charts. The internal grant charts are the basis for the preparation of the Financial Status Report. We found two out of three instances where a total of \$120,214 was not reported timely on the Financial Status Report because the internal reports were not updated.
- **Unliquidated obligations are not properly reported.** The report shows unliquidated obligations for both the federal and the State and local 25 percent matching portion. For the federal portion, the Division reports the amount of subgrants outstanding or for which expenditures are still expected. However, the Division has always shown \$0 for the State and local matching portion. In the grant status report for the quarter ending December 31, 1999, the unliquidated portion for the State and local percent match amounted to \$3.5 million. When subgrants are made, the match is also obligated, and portions not yet spent should be reported consistently with the federal portion as unliquidated obligations.

Any instance of inaccurate reporting of program income, administrative expenses, or unliquidated obligations by subgrantees needs to be addressed by the Division through improving report forms and instructions. Incorrect and inaccurate reports may ultimately jeopardize federal funding.

Recommendation No. 67:

The Division of Criminal Justice should develop procedures for preparing its federal Financial Status Reports that require:

- a. Distinct reporting of program income by grant year.
- b. Current data on administrative expenditures be reported.
- c. Reporting of the unobligated liquidations for the matching portion of the grant to maintain consistency with the federal unobligated portion.

Division of Criminal Justice Response:

Agree. The Division will work with grant managers and modify report forms and instructions to ensure accurate reports to the federal government by January 1, 2001.

Office of the State Treasurer

Introduction

The Office of the State Treasurer is established by the State Constitution and is responsible for efficiently managing the State's monies. The Office also manages the State's investments and implements and monitors the State's cash management procedures. Please refer to page 113 in the Financial Statement Findings section for additional background information.

Cash Management Improvement Act

The Cash Management Improvement Act (CMIA) regulates the transfer of funds between federal and state agencies for federal grants. The CMIA regulations require the State to match the time between incurring expenditures of federal funds and requesting and receiving reimbursement. States are required to enter into a Treasury - State Agreement (Agreement) with the U. S. Treasury. This Agreement specifies the procedures that the State will follow to carry out transfers of funds.

The State has just completed the first year of a new Agreement. The Agreement lasts five years (until Fiscal Year 2004) and may be modified by either party. In Fiscal Year 2000 there were 34 federal programs covered by CMIA at the Departments of Education, Health Care Policy and Financing, Human Services, Labor and Employment, Local Affairs, Public Health and Environment, Public Safety, and Transportation. These programs had expenditures of more than \$2 billion in Fiscal Year 2000.

Each year an Annual Report must be submitted to the Financial Management Service (FMS) of the U. S. Treasury by December 31. This report details any interest liability that is owed by the State or federal government.

Monitor Compliance With U. S. Treasury - State Agreement

The Treasurer's Office is responsible for ensuring that the State is in compliance with the U. S. Treasury - State Agreement. CMIA regulations require that the State calculate draw

patterns to match the time between when the funds are drawn and when they are needed. Draw patterns prescribe when each agency should request funds from the federal government so that, on average, federal funds are received the same time state funds are paid. During our Fiscal Year 2000 audit we found that the Treasurer's Office has not performed testwork to determine whether agencies are in compliance with specified draw patterns since Fiscal Year 1997.

During our current audit we noted that some agencies were not following the prescribed draw patterns. Failure to follow the appropriate draw patterns can result in an interest liability due to the federal government or lost interest earnings to the State. Unless agency compliance is periodically monitored, there is a risk that large liabilities could go undetected. Without independently determining whether state agencies are following the prescribed draw patterns and related provisions, the Treasurer's Office cannot certify the accuracy of the CMIA Annual Report or the State's compliance with the Agreement. During the period tested, the Treasurer's Office was not aware that state agencies were not following the prescribed draw patterns.

For example, at the Department of Public Safety we noted that the Department is drawing down funds about once a month instead of within five days of making an expenditure as required by the Agreement. We also determined that the Department of Human Services was out of compliance with CMIA. Although the Department implemented a new County Financial Management System in Fiscal Year 2000, the new system has not enabled the Department to implement drawdown practices consistent with CMIA requirements.

The Treasurer's Office should determine whether or not agencies are in compliance with CMIA. The Treasurer's Office could develop procedures to periodically test the draws and payments of warrants made by individual agencies. Procedures should include determining the dates that federal funds were requested and received for selected disbursements. Also, the Treasurer's Office should determine the dates that the federal funds were requested in accordance with the draw patterns prescribed in the Agreement by comparing the disbursement, request, and receipt dates.

Recommendation No. 68:

The Treasurer's Office should determine whether the State is in compliance with the Cash Management Improvement Act and that transfers of funds are made in a timely manner between federal and state agencies.

Treasurer's Office Response:

Agree. Treasury's responsibilities as State CMIA coordinator under Part 205 of the Code of Federal Regulations (CFR) include (1) coordinating all CMIA related interactions with the U.S. Treasury, (2) maintaining records supporting interest calculations, clearance patterns, direct costs, and other functions directly pertinent to the implementation and administration of CMIA, and (3) preparing the CMIA annual report.

Treasury agrees with the auditor's concern regarding interest liabilities from the non-compliance with CMIA draw schedules during the fiscal year. Although it is not feasible for Treasury independently to determine or test an agency's compliance with its CMIA draw schedule, Treasury will implement an improved monitoring process by December 31, 2000. This new plan will include semi-annual communications with appropriate State agencies and require written affirmation by each agency of its compliance with its draw schedules.

The U. S. Treasury - State Agreement Should Be Revised

The U. S. Treasury - State Agreement lists the programs that are covered by CMIA, the funding techniques, draw patterns for each agency, and the methods of calculating state and federal interest liabilities. As stated earlier, the State has just completed the first year of a new Agreement, which may be modified by either party. During our audit we noted the following errors in the current Agreement:

- **Three programs that were included in the Agreement did not meet the major program threshold as defined by the Treasurer's Office.** The Treasurer's Office determined that a program was covered under CMIA by establishing a threshold of \$7 million. In order to determine what programs were covered in the current Agreement, the Treasurer's Office reviewed the Schedule of Federal Expenditures for Fiscal Year 1998. Three programs included in the Agreement did not have total expenditures of more than \$7 million in Fiscal Year 1998.
- **One federally funded program at a university was inappropriately included in the Agreement.** CMIA regulations state that programs at institutions of higher education, hospitals, or nonprofit organizations are not subject to the Act's

requirements. In addition, this program was listed as being administered by the Department of Human Services in the Agreement.

- **One program that is not covered by the current CMIA Agreement was included in the 1999 Annual Report to the FMS.** The Annual Report shows the computation of any state and/or federal interest liability that occurred due to agencies' not following CMIA requirements. The Annual Report should include programs that are covered under the current Agreement. During our audit we noted that the Treasurer's Office included information for one program in the Annual Report that was not included in the current Agreement. Since there was no interest liability for this program, no dollars were reported. However, by including the program in the report, the U. S. Treasury is led to believe that the program is subject to and has complied with the Agreement.
- **One program has recently exceeded the threshold and should be included in the Agreement.** One program at the Department of Public Health and Environment had expenditures over \$7 million for the first time in Fiscal Year 2000. This program exceeded the CMIA threshold; therefore, the Agreement should be updated to include this program.

Programs included in the Agreement are subject to its terms. If programs do not meet the agreed-upon criteria but are still incorporated into the Agreement, the U. S. Treasury will expect that the mandated draw patterns will be followed. Since the Agreement can be modified, the Treasurer's Office should review the current Agreement to ensure that only applicable programs are included.

Recommendation No. 69:

The Treasurer's Office should review the current U. S. Treasury - State Agreement to ensure that only programs that are subject to the Cash Management Improvement Act are included in the Agreement.

Treasurer's Office Response:

Agree. Beginning in December 2000 and semi-annually thereafter, Treasury will send agency controllers a list of their existing CMIA grants and require them to make any changes in funding levels and to identify any new grants that meet the CMIA dollar threshold. The Treasury will review the information and, based upon the information provided, update the federal-state agreement.

Disposition of Prior Year Audit Recommendations

The following audit recommendations are summarized from the Statewide Audit for Fiscal Years 1999, 1998, 1997, and 1996. The Statewide Audit includes both financial audit and single audit recommendations.

Report and Rec. No.	Recommendation	Disposition
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Department of Corrections

1999 Single Audit Rec. No. 1	The Department of Corrections should record the receipt of all pharmaceuticals transferred into and out of the Pharmacy.	Implemented.
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Department of Education

1998 Single Audit Rec. No. 6	The Department of Education should strengthen its internal controls over subrecipient monitoring by determining which subrecipients are no longer subject to Single Audit requirements and developing a plan for monitoring each subrecipient.	Implemented.
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1998 Financial Audit Rec. No. 7	The Department of Education should complete the implementation of its disaster recovery plan for the HP 3000 system by purchasing a backup system and testing the backup system regularly.	Implemented.
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**Report and
Rec. No.**

Recommendation

Disposition

**Department of Health Care Policy and
Financing**

1999 Single Audit
Rec. No. 2

The Department of Health Care Policy and Financing (HCPF) should prioritize completion and submission of cost allocation plans for Fiscal Years 1999, 1998, and 1995, including the development of time-and-effort studies or similar methodology to support the plans to be submitted.

Partially implemented. As of September 29, 2000, the Department received federal approval, through the Health Care Financing Administration, of the Fiscal Year 1995 through 1999 cost allocation plans. However, the Department has not submitted a plan for Fiscal Years 2000 or 2001. Approved cost allocation plans should be in place prior to the beginning of the fiscal year. See current year Recommendation No. 5.

1999 Single Audit
Rec. No. 3

The Department of Health Care Policy and Financing should ensure payments are made only for allowable costs under the Medicaid program by (a) improving controls over third-party resources, (b) establishing claims reviews, (c) requiring detailed support for claims, (d) ensuring that Electronic Data Interchange agreements are current, and (e) requiring that providers submit client signature logs to facilitate reviews.

Part a. and b: Partially implemented. The Department's fiscal agent for Medicaid has partially implemented "Intent to Retract" procedures to recover amounts related to third-party resources. See current year Recommendation No. 34.

Part c: Partially implemented. See current year Recommendation No. 39.

Part d: Not implemented. See current year Recommendation No. 34.

Part e: Implemented.

**Report and
Rec. No.****Recommendation****Disposition**

1999 Single Audit
Rec. No. 4

The Department of Health Care Policy and Financing should ensure adequate controls are in place over automated systems for the Medicaid program by performing and documenting analysis for the Medicaid Management Information System (MMIS) and considering a requirement that the fiscal agent obtain an independent assessment of controls over the MMIS.

Not implemented. See current year Recommendation No. 35.

1999 Single Audit
Rec. No. 5

The Department of Health Care Policy and Financing should enhance control procedures and review processes for federal drawdowns under the Medicaid program by (a) establishing standardized procedures that specifically address the manual Disproportionate Share Hospital program transactions and prevent duplicate federal drawdowns, and (b) implementing review procedures that compare expenditures and allotments, and determine if a request for supplemental federal funds needs to be submitted.

Part a: No longer applicable. All drawdowns are now completed under the normal drawdown process.

Part b: Implemented.

**Report and
Rec. No.****Recommendation****Disposition**

1999 Single Audit
Rec. No. 6

The Department of Health Care Policy and Financing should recognize and work to meet federal limits for non-benefit activity costs under the Children's Health Insurance Program by (a) recording a liability quarterly for federal reimbursement received related to expenditures in excess of the 10 percent limit, (b) developing a strategy to ensure non-benefit activity costs are appropriately reduced, and (c) informing the General Assembly on the status of reducing non-benefit activity costs to the required level.

Part a: Implemented.

Part b: Partially implemented. The Department continues to work on a strategy to reduce administrative costs to the necessary level. These costs were budgeted not to exceed the federal limit for receiving matching funds for Fiscal Year 2001. We will continue our follow-up in Fiscal Year 2001.

Part c: Not implemented. We will continue our follow-up in Fiscal Year 2001.

1999 Single Audit
Rec. No. 23

The Department of Health Care Policy and Financing should strengthen controls over Medicaid client eligibility processes by (a) reviewing and documenting the Department of Human Service's Single Entry Point monitoring, (b) working with the Department to implement control procedures to ensure all county departments of social services are maintaining current Medicaid files, and (c) establishing procedures to ensure claims are not being paid and individuals are disenrolled if they are not eligible for benefits.

Part a: Implemented.

Part b: Partially implemented. The Department of Health Care Policy and Financing has revised its agreement with the Department of Human Services to strengthen monitoring of Single Entry Point entities and provide additional training on requirements. See current year Recommendation No. 36.

Part c: Not implemented. See current year Recommendation No. 36.

Report and Rec. No.	Recommendation	Disposition
1999 Single Audit Rec. No. 24	The Department of Health Care Policy and Financing should improve controls over provider eligibility by (a) requiring current provider agreements and applicable provider licenses, (b) revising procedures to ensure expenditures are made only to eligible providers, and (c) including notification provisions in the interagency agreement in the event a mental health provider loses its license or certification under the Medicaid program.	Parts a and b: Not implemented. See current year Recommendation No. 37. Part c: Deferred. The interagency agreement between HCPF and the Department of Human Services was revised effective July 1, 2000. We will continue our follow-up in Fiscal Year 2001.
1999 Single Audit Rec. No. 25	The Department of Health Care Policy and Financing should ensure all necessary complaint information is maintained under the Medicaid Managed Care Program by requiring all complaints under the Programs for All Inclusive Care for the Elderly be reviewed; continue to monitor providers participating in the managed care program.	Not implemented. See current year Recommendation No. 38.
1999 Single Audit Rec. No. 26	The Department of Health Care Policy and Financing should require that case files contain supporting documentation in chronological order from case opening to disposition with a corresponding log of the case history.	Not implemented. See current year Recommendation No. 39.
1999 Single Audit Rec. No. 27	The Department of Health Care Policy and Financing should develop an overall framework to heighten accountability for fighting Medicaid fraud and abuse.	Implemented.

Report and Rec. No.	Recommendation	Disposition
1999 Single Audit Rec. No. 28	The Department of Health Care Policy and Financing should work with the Medicaid Fraud Control Unit to recover past-unrefunded prescription credits and monitor future prescription refunds to make sure new pharmacy program controls are working as intended.	Partially implemented. The Department implemented requirements related to signature logs documenting recipients' receipt of prescriptions on June 1, 2000. The Department needs to implement procedures to monitor these logs to ensure prescription credits are received in appropriate instances. See current year Recommendation No. 34.
1999 Single Audit Rec. No. 29	The Department of Health Care Policy and Financing should ensure that all nursing facilities receive in-depth reviews of billing practices and personal needs funds on a systematic basis.	Deferred. The Department is currently awaiting a response from the Joint Budget Committee regarding contingency-based contracting. We will continue our follow-up in Fiscal Year 2001.
1999 Single Audit Rec. No. 30	The Department of Health Care Policy and Financing should undertake a comprehensive review of high-risk programs that result in inappropriate payments and modify its policies and procedures to prevent payment of inappropriate claims.	Partially implemented. The Fraud and Abuse Task Force has reviewed and prioritized high-risk programs. The Department is in the process of drafting more stringent Program Integrity rules. Implementation date: February 1, 2001. In addition, the Program Integrity Unit will develop a Request for Proposal (RFP) for a contingency-based contract for post-payment reviews focused on high-risk programs. Implementation date for posting of RFP: June 2001.
1999 Single Audit Rec. No. 31	The Department of Health Care Policy and Financing should review and revise regulations, statutes, application materials, and provider agreements to reduce fraud and abuse.	Deferred. We will continue our follow-up in Fiscal Year 2001.

Report and Rec. No.	Recommendation	Disposition
1999 Single Audit Rec. No. 32	The Department of Health Care Policy and Financing should work with the Medicaid Fraud Control Unit to propose legislation that establishes anti-kickback and civil false claims statutes, and anti-unbundling regulations.	Partially implemented. State civil monetary law was proposed and defeated during the 2000 Legislative Session. The Department plans to propose similar legislation during the 2001 Legislative Session. The Department has proposed regulations related to anti-unbundling. Implementation date for regulations: February 1, 2001.
1999 Single Audit Rec. No. 33	The Department of Health Care Policy and Financing should obtain date of death information for use in seeking recoveries for past inappropriate claims and preventing payment for services provided after date of death in the future.	Implemented.
1999 Single Audit Rec. No. 34	The Department of Health Care Policy and Financing should work with its fiscal agent to verify and document that all required application materials are included with the initial application and that application materials are filled out completely before enrollment into the Medicaid program.	Not implemented. See current year Recommendation No. 36.
1999 Single Audit Rec. No. 35	The Department of Health Care Policy and Financing should ensure that case files for the Children's Health Insurance Program clearly document the eligibility status for each child.	Deferred. We will continue our follow-up in Fiscal Year 2001.
1997 Single Audit Rec. No. 2	The Department of Health Care Policy and Financing should improve its management of accounts receivable by ensuring reconciliations are complete and performed in a timely manner and by further automating the reconciliation process.	Partially implemented. The Department continues not to reconcile federal due to/from accounts. We will continue our follow-up in Fiscal Year 2001.

Report and Rec. No.	Recommendation	Disposition
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1997 Single Audit Rec. No. 3	The Department of Health Care Policy and Financing should improve its oversight of the collection of Medicaid overpayments by improving the tracking, reporting, and analysis of identified overpayments and using this information to aid county collection efforts.	Implemented.
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Department of Higher Education

Board of Regents of the University of Colorado

1999 Single Audit Rec. No. 7	The University of Colorado Health Sciences Center should ensure compliance with federal and University regulations, policies, and procedures concerning grants purchases and dispositions of federally funded assets over \$5,000.	Implemented.
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Colorado Historical Society

1999 Single Audit Rec. No. 8	The State Historical Fund should develop standard criteria to be documented and used in determining the level of monitoring to occur for historical preservation projects.	Implemented.
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1996 Financial Audit Rec. No. 9	The Colorado Historical Society should review TOP SECRET violation reports or implement alternative procedures for monitoring information system security violations.	Implemented.
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**Report and
Rec. No.**

Recommendation

Disposition

Colorado Student Loan Division

1999 Single Audit
Rec. No. 36

The Colorado Student Loan Division should work with the State Treasurer's Office to resolve problems with the outstanding check reports.

Partially implemented. The Division has worked with the State Treasurer's Office to resolve reconciling items from eighteen as of June 30, 1999 to three as of June 30, 2000. The Bank's outstanding check balance now agrees with the beginning of the next month. The Division should continue to resolve outstanding items. We will continue our follow-up in Fiscal Year 2001.

1999 Single Audit
Rec. No. 37

The Colorado Student Loan Division should continue to exercise due diligence to obtain information from the lenders on loans closed by the lender.

Partially implemented. The Division took steps to identify and resolve loans where no reporting has occurred by assigning their Compliance, Training, and Investigation Division to focus on unreported loans while performing lender audits in Fiscal Year 2000. However, we found that there are still differences between the lender's records and the Division's records. Full implementation is planned for Fiscal Year 2002.

**Report and
Rec. No.**

Recommendation

Disposition

Trustees of the Colorado School of Mines

1999 Single Audit
Rec. No. 38

The Colorado School of Mines should establish policies and procedures to ensure compliance with federal requirements by (a) identifying all entities that receive federal funds from the University and evaluating which entities are subrecipients and monitoring subrecipients as dictated by the federal government, (b) developing a plan and timetable for eliminating the backlog of grant close-out reports, (c) retaining appropriate documentation to demonstrate compliance with federal matching requirements, and (d) reporting non-cash assistance in accordance with federal requirements.

Part a: Not implemented. See current year Recommendation No. 54.

Parts b, c, and d: Implemented.

State Board of Agriculture

1998 Single Audit
Rec. No. 8

The University of Southern Colorado should improve the process for Perkins loans by implementing changes to keep borrower information current and accurate and utilizing a system-generated comparison to determine that all students reported as in school are registered for classes at the University or meet other eligibility requirements.

Implemented.

Department of Human Services

1999 Single Audit
Rec. No. 9

The Department of Human Services should implement a methodology for accumulating, recording, and reporting revenue within all divisions that includes adequate reconciliation procedures and utilizes automated systems.

Implemented.

Report and Rec. No.	Recommendation	Disposition
1999 Single Audit Rec. No. 10	The Department of Human Services should require supervisory or secondary review of all manually calculated payroll transactions.	Implemented.
1999 Single Audit Rec. No. 11	The Department of Human Services should improve controls over the personnel process by implementing a monitoring process to ensure that employee performance evaluations are completed annually and enforcing disciplinary actions when annual performance evaluations are not completed.	Implemented.
1999 Single Audit Rec. No. 39	The Department of Human Services should improve the on-site review process for the Adoption Assistance Program by implementing a risk-based approach for selection of counties to be monitored; using a random-sampling method for case file selection; documenting review procedures to be performed; providing written results of the review to appropriate county management; and requiring counties to correct noted deficiencies.	Implemented.
1998 Financial Audit Rec. No. 12	The Department of Human Services should improve controls over fixed assets by (a) improving oversight and coordination, (b) enforcing the use of standard procedures, and (c) resolving items designated as “unlocated”.	<p>Part a: Partially implemented. The Department has improved its oversight and coordination over the fixed asset reconciliation process. However, we noted problems with reconciliations for several agencies within the Department. We will continue our follow-up in Fiscal Year 2001.</p> <p>Part b and c: Implemented.</p>

**Report and
Rec. No.****Recommendation****Disposition**

1998 Single Audit
Rec. No. 13

The Department of Human Services should implement on-site monitoring of county activities for the Temporary Assistance for Needy Families program to ensure that federal and state requirements are met.

Implemented.

1998 Single Audit
Rec. No. 14

The Department of Human Services should improve its fiscal management system for federal programs by (a) implementing a method for identifying payments made for Electronic Benefit Transfer (EBT) programs by grant, requesting appropriate cash reimbursement in a timely manner, and tracking information linking specific disbursements to cash draws and cash receipts; and (b) ensuring that future changes that affect its cash management and accounting process are included in the overall grant management process.

Part a. Partially implemented. While the Department has made improvements in this area, we found that the Department had large receivable balances for several major programs. The Department has implemented a manual tracking method for linking specific disbursements to cash draws and cash receipts for non-EBT programs. We will continue our follow-up in Fiscal Year 2001.

Part b. Ongoing.

1997 Single Audit
Rec. No. 9

The Division of Vocational Rehabilitation should (a) examine the types of services it purchases and develop a process for competitively bidding those services, and (b) work with the Division of Purchasing to ensure that its new procedures comply in all respects with purchasing requirements.

Partially implemented. We will continue our follow-up in Fiscal Year 2001.

Judicial Department

1998 Financial
Audit Rec. No. 18

The Judicial Department should consolidate their bank accounts and deposit them with the State Treasury's pooled account to the greatest extent legally possible.

Deferred. The Department will research this with the State Treasury in hopes of implementation in Fiscal Year 2001.

**Report and
Rec. No.**

Recommendation

Disposition

Department of Labor and Employment

1999 Single Audit
Rec. No. 12

The Department of Labor and Employment should perform a reconciliation of federal revenue from the Department's grant accounting system to the State's accounting system annually.

Partially implemented. The Department has succeeded in identifying several reconciling items that impact the difference between deferred revenue per the Schedule K-1 based on its grant system and the amount of the federal receivable in the State's system. When those items were included in this year's reconciliation, the difference between the two systems was immaterial. The Department will continue to further identify those items that cause the difference until assurance of recording of federal revenue is fully accurate in the State's system. Department personnel will begin performing the reconciliation in Fiscal Year 2001.

Department of Natural Resources

1998 Financial
Audit Rec. No. 21

The Department of Natural Resources should identify goods and services that could be purchased in volume through competitive bids and obtain the necessary documented quotes or bids as required.

Implemented.

1997 Single Audit
Rec. No. 12

The Department of Natural Resources should complete the review and correction of information on the report tracking system to ensure that schedules contain correct due dates.

Implemented.

**Report and
Rec. No.****Recommendation****Disposition**

1997 Financial
Audit Rec. No. 14

The Department of Natural Resources should establish departmentwide policies and procedures for processing each federal grant by coordinating between program and accounting staff and following up on problems with grants.

Implemented.

1996 Financial
Audit Rec. No. 16

The Department of Natural Resources should strengthen management controls over the processing and review of payment voucher transactions to prevent vendor payment errors.

Deferred. We will continue our follow-up in Fiscal Year 2001.

Division of Minerals and Geology

1999 Single Audit
Rec. No. 13

The Division of Minerals and Geology should identify discrepancies between the State Treasury's records for mined land reclamation cash deposits and the State's accounting records.

Partially implemented. The Division has identified interest as the difference between the State Treasury's records and the State's accounting records. The Division is in the process of preparing a spreadsheet to track interest by individual cash bond. We will continue our follow-up in Fiscal Year 2001.

1998 Financial
Audit Rec. No. 27

The Division of Minerals and Geology should ensure that all deposits are in compliance with statutory and other legal requirements. The Division should ensure that short-term certificates are moved to eligible public depositories on their next maturity date and develop a plan for long-term certificates.

Not implemented. See current year Recommendation No. 24.

**Report and
Rec. No.****Recommendation****Disposition****Oil and Gas Conservation Commission**

1998 Financial
Audit Rec. No. 26

The Oil and Gas Conservation Commission should ensure that all deposits are in compliance with statutory and other legal requirements. The Division should ensure that short-term certificates are moved to eligible public depositories on their next maturity date and develop a plan to address any long-term certificates.

Not implemented. See current year
Recommendation No. 23.

Division of Wildlife

1998 Financial
Audit Rec. No. 22

The Division of Wildlife should reconcile sales recorded in the CORIS inventory module to license revenue recorded on the State's accounting system by determining the system differences for recording license revenue between CORIS and the State's accounting system; modifying the inventory system to address identified differences; and reconciling the two systems annually.

Implemented.

1998 Financial
Audit Rec. No. 23

The Division of Wildlife should improve hunting and fishing license controls by (a) reducing excess inventories of licenses, (b) tracking void licenses separately, and (c) recording refunds on CORIS.

Parts a and b: Not implemented. See current year
Recommendation No. 22.

Part c: Implemented.

1998 Financial
Audit Rec. No. 24

The Division of Wildlife should improve grant management and reduce unspent grant balances by encouraging progress billings from Division contractors and ensuring that contracts do not extend beyond federal grant periods.

Implemented.

**Report and
Rec. No.****Recommendation****Disposition**

1997 Financial
Audit Rec. No. 18

The Division should improve the controls over its inventory by maintaining perpetual records that account for inventory transactions, ensuring consistency in recording all items for sale as inventory in the State's accounting system, periodically writing off obsolete inventory on the State's accounting system and evaluating the need to include the merchandise located in the service centers as inventory.

Implemented.

**Department of Personnel d. b. a. General
Support Services**

1999 Single Audit
Rec. No. 17

General Support Services should classify revenue properly for TABOR purposes by ensuring that there is adequate follow-up on information submitted by the state agencies and routinely analyzing financial statement information.

Not implemented. The Department added directions to the billings on how to report TABOR revenue; however, we continued to find errors. In addition, no analysis was done to determine the reasonableness of the amounts reported by agencies. We will continue our follow-up in Fiscal Year 2001.

1999 Single Audit
Rec. No. 18

General Support Services should follow written procedures and store the backup of Central Collection records in a secured off-site location.

Implemented.

1998 Financial
Audit Rec. No. 28

General Support Services should monitor compliance with annual performance evaluation and supervisor sanction provisions and report the results of its monitoring to the Joint Budget Committee.

Implemented.

Report and Rec. No.	Recommendation	Disposition
1998 Financial Audit Rec. No. 29	General Support Services should include a requirement for an independent auditor's report on the processing of the State's Deferred Compensation Plan transactions in the contract with the Plan's administrator or establish procedures to document and test the administrator's internal controls over the processing and reporting of Plan transactions beginning with Fiscal Year 1999.	Implemented.
1998 Financial Audit Rec. No. 30	General Support Services should improve controls over Central Collections' internal collection system by performing a monthly reconciliation between the State's accounting system and the internal collection system and requiring additional password protection be implemented.	Implemented.
1998 Financial Audit Rec. No. 31	General Support Services should develop, implement, and enforce procedures for the deposit of all monies and for the update of the accounts receivable system in a timely manner at Telecommunications.	Implemented.
State Controller's Office		
1999 Single Audit Rec. No. 14	The State Controller's Office should refine the methods used to compile the statement of cash flows by utilizing all available information, working with agencies to ensure that transactions are properly categorized, improving the methodology to compile the statement, and netting warrants payable against cash.	Implemented.

Report and Rec. No.	Recommendation	Disposition
1999 Single Audit Rec. No. 15	The State Controller's Office should strengthen the procedures used to compile the Cash Funds Uncommitted Reserves Report by providing training to agency personnel and developing analytical review procedures.	Implemented.
1999 Single Audit Rec. No. 16	The State Controller's Office should develop and document improved analytical review techniques for TABOR revenue.	Implemented.
1998 Financial Audit Rec. No. 1	The State Controller's Office should provide additional training and assistance in areas where agencies are inconsistently reporting financial information that is used to prepare the State's financial statements.	Implemented.
Department of Public Health and Environment		
1999 Single Audit Rec. No. 19	The Department of Public Health and Environment should establish, implement, and monitor departmentwide security policies and practices for information systems.	Implemented.
1999 Single Audit Rec. No. 20	The Department of Public Health and Environment should assemble a team with appropriate representatives to define the procedures for documenting application events, vendor responses, and communicating information. The team should follow up and report on findings of the Post Implementation Review.	Partially implemented. Procedures have been defined, but the review has not yet been completed. We will continue our follow-up in Fiscal Year 2001.
1997 Financial Audit Rec. No. 22	The Department of Public Health and Environment should evaluate the current time-and-effort system in order to obtain information needed in a timely manner to manage expenditure levels and prepare billings.	Implemented.

**Report and
Rec. No.****Recommendation****Disposition**

1997 Financial
Audit Rec. No. 23

The Department of Public Health and Environment should develop a comprehensive disaster recovery plan.

Deferred. The Department is collecting disaster recovery templates as a first step in developing a disaster recovery plan. Implementation is expected to be complete by the end of 2001. We will continue our follow-up in Fiscal Year 2001.

Department of State

1999 Single Audit
Rec. No. 21

The Department of State should strengthen the controls over financial transactions by performing and documenting timely reconciliations for property and equipment, and payroll.

Partially implemented. The Department has implemented the recommendation to perform and document a reconciliation of payroll. The recommendation for reconciling property and equipment has been deferred. We will continue our follow-up in Fiscal Year 2001.

Department of Transportation

1999 Single Audit
Rec. No. 22

The Department of Transportation should transfer custody of the credit card reconciliation program to the Information Technology Division and maintain it in accordance with the Department's procedures to protect the data against unauthorized access.

Partially implemented. Programming efforts for this activity are in process. Due to funding constraints, these efforts have been segregated by phase. The initial phase is scheduled for implementation by May 2001. The second phase will be programmed during Fiscal Year 2002.

1998 Single Audit
Rec. No. 17

The Department of Transportation should enforce the contractor payroll review requirements and work with prime and subcontractors to train them in proper payroll procedures.

Implemented.

**Report and
Rec. No.****Recommendation****Disposition**

1998 Single Audit
Rec. No. 18

The Department of Transportation should train project engineers in the purpose and requirements of the Form #280 and require its regional Equal Employment Opportunity (EEO) representatives to take an active role in monitoring the quantity, quality, and timeliness of forms completion.

Partially implemented. Approximately 85 percent of the engineering staff have attended training related to their monitoring responsibilities. Additionally, consultants involved in construction management have also attended this training. This training effort will be ongoing. We will continue our follow-up in Fiscal Year 2001.